COMAR 10.25.06 – ***Maryland Medical Care Data Base and Data Collection***

MEDICAL CARE DATA BASE

2012 MCDB

DATA BASE SUBMISSION MANUAL

MARYLAND HEALTH CARE COMMISSION
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MARYLAND HEALTH CARE COMMISSION

COMAR 10.25.06 – MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION MANUAL

TABLE OF CONTENTS

SECTION

APPENDICES

DATA SUBMISSION MANUAL

PURPOSE: The 2012 Medical Care Data Base (MCDB) Data Submission Manual is designed to provide payers with guidelines of technical specifications, layouts, and definitions necessary for filing the Professional Services Data, Pharmacy Data, Provider Directory, Institutional Services Data, and Medical Eligibility Data reports required under COMAR 10.25.06.01B. This manual incorporates new information, and all recent updates and modifications outlined in the 2011 MCDB Data Submission Manual released April, 2012. Only items that are new or modified in the current version are so indicated. The manual is available in electronic form on the Commission's website at mhcc.dhmh.maryland.gov.

PAYER ID #: Please see Appendix A for a list of 2012 MCDB payers and assigned Payer ID numbers. The Payer assigned ID number is required on all submission media and documentation.

Questions regarding the information in this manual should be directed to:

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For information on the MCDB SFTP submission process contact:

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DATA SUMMARY WORKSHEETS (DSW)

(replaces MCDB Data Completeness Summary Report)

Payers who contributed to the 2011 Medical Care Data Base (submissions received June 2012) will be mailed Data Summary Worksheets *(replaces Data Completeness Summary Report)* that shows total number of users, services, and payments for the claims file, and enrollees and member months for the eligibility file for calendar years 2010 and 2011.

Please use this report to evaluate changes between your 2011 data (submitted in June 2012) and this 2012 MCDB data submission by inserting the 2012 reported data in the appropriate column. If there are decreases or increases above 10 percent you must provide detailed documentation with your current submission.

If your company did not receive the 2011 Data Summary Worksheets, please contact Larry Monroe at larry.monroe@maryland.gov.

MARYLAND HEALTH CARE COMMISSION

DATA SET GLOSSARY

I. REPORTING PERIOD: **Claims adjudicated** between January 1, 2012 through April 30, 2013 for services provided and prescriptions filled between January 1, 2012 through December 31, 2012. The MCDB data regulations limit the span of service dates to be included in the data submission to only those services provided during the requested calendar year; services provided in the initial months of the subsequent year are no longer being collected. Payers should still utilize a four month run-out period in the subsequent year to create their service files, submitting all 2012 services that had been paid as of April 30, 2013.

[Note: Any service provided or prescription filled after December 31, 2012 or crosses over the year 2012 into 2013 (e.g., 01/01/13 thru 04/30/13) should not be included in the 2012 MCDB submission, but submitted with the 2013 MCDB data (due June 30, 2014).]

Include claims for all Maryland residents covered by your company regardless of where the contract is written; for example, if your company covers Maryland residents under a contract written in California, the claims for these residents should be included in your submission. Additionally, we are requesting that carriers provide claims and coverage information for all non-Maryland residents covered under Maryland contracts.

For 2012, we are asking carriers to submit eligibility and claim information for Maryland residents insured under fully insured and self-insured contracts and for non-Maryland residents insured under Maryland contracts. Claim information for non-Maryland residents are needed for a number of health care reform initiatives including the State's Patient Centered Medical Home (PCMH) program. In 2012, we will modify our regulations to align with this requirement.

II. MEDICAL ELIGIBILITY REPORT: This data report details information on the characteristics of all enrollees covered for medical services under the plan from **January 1, 2012 through December 31, 2012**. Please provide an entry for each month that the enrollee was covered by a health benefit plan regardless of whether or not the enrollee received any covered services during the reporting year.

(For example, an enrollee with 12 months of coverage will have 12 eligibility records; an enrollee with 6 months of coverage will only have 6 records.)

III. PROFESSIONAL SERVICES REPORT: Fee-for-service encounters and capitated encounters provided by health care practitioners and office facilities (i.e., CMS 1500 claims).

This does not include hospital facility services documented on UB-04 claims forms.

The following medical services must be included:

- Physician services
- Non-physician health care professionals
- Freestanding Office Facilities (radiology centers, ambulatory surgical centers, birthing centers, etc.)
- Durable Medical Equipment (DME)
- Prescription Drug (in a separate file)
- Dental – if services are provided under a medical benefit package
- Vision - if services are provided under a medical benefit package

IV. PHARMACY REPORT: This data file details prescription drugs services only.

V. PROVIDER DIRECTORY REPORT: This data report details all health care practitioners and suppliers who provided services to enrollees during the reporting period. Each professional service submission should be accompanied by a Provider Directory Report. In instances where the data come from different sources, a separate Provider Directory Report must be provided (with a crosswalk of every practitioner ID listed in the Professional Services Report) for each health care practitioner or supplier who provided services.

DATA SET GLOSSARY (cont.)

VI. INSTITUTIONAL SERVICES REPORT: This data file reports all institutional health care services provided to Maryland residents, whether those services were provided by a health care facility located in-State or out-of-State. These services include all payments made by the plan to the Institutional provider summarized on the final bill for the given stay or visit. This summary record should reflect all charges and payments from an interim or final claim. To avoid sending duplicate charges and payments, submit summaries from interim claims only when a final claim does not exist for a visit or stay.

VII. REPORTING DEADLINE: June 30, 2013

VIII. NUMBER (#) OF SERVICES: Any health or medical care procedure or service rendered by a health care practitioner documented by CPT, HCPCS or locally defined code (i.e., homegrown medical procedure code).

- **Fixed Format** – 1 service corresponds to 1 record/service. If a service includes more than 1 unit, it is still counted as 1 service.
- **Variable Format** – 1 service is equal to 1 line item, multiple line items can appear on a single record/claim.

IX. NUMBER (#) OF CLAIMS:

- **Fixed Format** – Claims are equal to the number of CMS 1500 encounters (bills) or UB-04 claims originally received. Please note that when using the fixed format this number will not conform with the number of records submitted because multiple services may be reported on a single claim.
- **Variable Format** – Number of claims is equal to the number of CMS 1500 encounters (bills) or UB-04 claims submitted.

MARYLAND HEALTH CARE COMMISSION

OVERVIEW OF DATA SUBMISSION GUIDELINES

GENERAL –

- The 2012 MCDB data submission marks the fourth year of compliance under **COMAR 10.25.06 Maryland Medical Care Data Base and Data Collection**, regulations that became effective on April 19, 2010. These regulations can be accessed via the Commission's website at: http://mhcc.maryland.gov/payercompliance.

- **16-month Reporting Period – claims adjudicated** between January 1, 2012 through April 30, 2013 for services provided and prescriptions filled between January 1, 2012 through December 31, 2012.

  [Note: Any service provided or prescription filled after December 31, 2012 or crosses over the year 2012 into 2013 (e.g., 01/01/13 thru 04/30/13) should not be included in the 2012 MCDB submission, but submitted with the 2013 MCDB data.]

- The **Professional Services** File should include all fee-for-service and specialty capitated care encounters for services provided by health care practitioners and office facilities to Maryland residents during the reporting period. (**COMAR 10.25.06.06**)

- The **Pharmacy Services** File should include all pharmacy services provided to Maryland residents during the reporting period, whether the services were provided by a pharmacy located in Maryland or out-of State. (**COMAR 10.25.06.07**)

- The **Provider Directory** should include information on all Maryland and out-of-State health care practitioners and suppliers that provided services to Maryland residents during the reporting period. (**COMAR 10.25.06.08**)

- The **Institutional Services** Claims File should include all institutional health care services provided to Maryland residents during the reporting period. (**COMAR 10.25.06.09**)

- The **Medical Eligibility** File should include information on the characteristics of all enrollees covered for medical services under the plan during the reporting period. (**COMAR 10.25.06.10**)

- As a reminder for payers submitting the MCDB data files directly to the **MHCC Secure SFTP site**, the **Internet Protocol (IP) Address** for the SFTP site is **184.80.193.37**. Information on submission of files to the Commission's SFTP Server can be found in Appendix B (pg. 38). Note that your company's assigned User ID and Password remain the same.

KEY SPECIFICATIONS –

- Match the **layout of the file submission** with the appropriate file layout, not with the data dictionary. The order of the variables in the data dictionary reflects the data regulations, and additional variables, not the file layout. For example, the financial data elements appear in the middle of the data dictionary, but should be included at the end of the Institutional Services file layout, as described in the file layout.

- The **Record Identifier** field is used to identify the data report file: 1 – Professional Services; 2 – Pharmacy Services; 3 – Provider Directory; 4 – Institutional Services; 5 – Medical Eligibility.

KEY SPECIFICATIONS (cont.) –

- The Commission requests that payers continue to provide the **Patient/Enrollee IdentifierU** using the **Universally Unique Identifier (UUID)** algorithm to uniquely encrypt patient/enrollee identifiers, as required under **COMAR 10.25.06.05**. This unique identifier enables the Commission to identify patients across payers over time.

- The full **Universally Unique Identifier (UUID)** encryption software documentation, source code, and executables are bundled into a ZIP file. That software can be downloaded directly from the Commission's website at http://mhcc.dhmh.maryland.gov/payercompliance/Pages/mcdb-uuid.aspx. The file is password protected. The password will be forwarded to the payer contact in an e-mail.

- Carriers are required to continue to use their current encrypted identifier, **Patient/Enrollee IdentifierP**, coincident with the new identifier. Using two identifiers will: 1) provide the means to perform trend analysis by cross referencing the two identifiers, and 2) increase the efficacy of the identifiers in the event encryption of one of the algorithms is compromised.

- The **Payer ID Number** and **Source System** fields, on the Professional Services, Pharmacy Services, Provider Directory, Institutional Services, and Medical Eligibility data reports, allow the Commission to identify the **payer platforms** or **business units** from which the data was obtained.

- The **Source Company** variable (pg. 15, pg. 28, pg. 66, pg. 95) on the Professional Services File and Medical Eligibility File defines the **payer company** that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.

- The **Product Type** field (pg. 18, pg. 27, pg. 70, pg. 95) on the Professional Services File and Medical Eligibility File classifies the **benefit plan** by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits).

- Total Patient Liability should equal the sum of **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. These three financial fields **must be reported when available**. Please make an effort to provide this financial information.

- The **Plan Liability** flag is configured into three categories: (1) Risk – under a Maryland contract; (2) Risk under a non-Maryland contract; or (3) Administrative Services Only (pg. 17, pg. 27)

- The **Record Status** field on the Professional Services File replaced (renamed for) "Type of Bill" (pg. 19, pg. 66).

- On the Institutional Services File, the **Record Status** field will be determined using the **third digit** in the "Type of Bill" field (pg. 25, pg. 88), so please fill this field. To avoid sending duplicate charges and payments, submit summaries from interim claims only when a final claim does not exist for a visit or stay.

- New! The **Place of Service** field on the Professional Services File has been updated to include **"Walk-in Retail Health Clinic"** (code #17, pg. 31, pg. 32). This new value aligns the MCDB categories with the CMS Place of Service code set.

- The **Point of Origin for Admission or Visit** *(formerly Source of Admission)* variable on the Institutional Services File reflects changes in the Centers for Medicare and Medicaid Services (CMS) Medical Claims Processing Manual Code List.

- Payers are reminded to **NOT encrypt** the **Employer Federal Tax ID** (pg. 62) on the Medical Eligibility File. The data base contractor **will encrypt** the Employer Federal Tax ID prior to creating the MCDB files. Under this new encryption protocol, an employer will have the same encrypted ID across all payer records.

KEY SPECIFICATIONS (cont.) –

- **Patient Date of Enrollment** in plan – Date is **20120101** if patient is enrolled at start of 2012. Enter other date if patient **not enrolled** at start of year but enrolled during 2012.

- **Patient Date of Disenrollment** in plan **– Leave blank** if patient is **still enrolled** on **20121231**. If patient **disenrolled** before end of year, enter date disenrolled.

- The **Date of FIRST Enrollment** (pg. 63, pg. 96) on the Medical Eligibility File should reflect the date that the patient was **initially enrolled with your organization**.

- On the Medical Eligibility File, the **Start Date of Coverage (in the month)** represents the **start date for benefits** in the month. (For example, if the enrollee was insured at the start of the month of January in 2012, the start date is 20120101.)

- Also, the **End Date of Coverage (in the month)** on the Medical Eligibility File represents the **end date for benefits** in the month. (For example, if the enrollee was insured for the entire month of January in 2012, the end date is 20120131.)

- Payers **MUST** provide the National Provider Identifier (NPI) number where requested. Reporting of key NPI numbers is required for the development of a provider performance measurement system.

- NPI numbers requested include: **Servicing Practitioner** Individual NPI number and **Practitioner NPI used for Billing** on the Professional Services File; the **Prescribing Practitioner** Individual NPI on the Pharmacy File; and, the **Attending Practitioner** Individual NPI on the Institutional Services File.

MCDB Data Summary Worksheets and Quality Review Summary Reports:

- MHCC provides payers with the prior submission year's Data Summary Worksheets *(replaces Data Completeness Summary)* and Quality Review Statement reports with comments for review by payers; QRS designed to provide payers with a comparison of information reported and threshold values assigned; DSW details changes in key measures including total number of recipients, services, and payments from the previous year's information.

- In an effort to reduce back and forth communications and re-submissions, payers are asked to use the Data Summary Worksheets to compare key measures from the current submission to the value for the same measures in their prior year's submission and calculate percent changes before submitting data.

- Payers are required to screen results for noteworthy changes (decreases or increases above 10%) in all key variable categories.

- Payers must provide information/documentation on significant changes prior to current submission to confirm if differences are legitimate as opposed to data submission errors, that is an explanation of why their submission for the current year differs significantly from that of the previous year.

WAIVER or EXCEPTION REQUESTS –

- The deadline for filing requests for waiver exemptions or format exceptions is **May 20, 2013**. An extension request will be granted only if the payer can demonstrate extraordinary cause. The data base contractor is not authorized to grant exceptions.

- Payers are reminded to submit waiver requests only for those data elements that have an **assigned threshold value**.

- The MHCC staff assesses each payer's waiver request(s) based on that **payer's particular circumstances**, including specific claims information provided to or retained by the payer, and changes in staffing or claims processing and storage systems that may impact information the payer can submit or when the submission can be completed.

- It is important that payers reference the MCDB **Quality Review Statement** (QRS) before submitting their data element and modified threshold waiver requests. The QRS is designed to provide payers with a comparison of information reported and threshold values assigned.

- Payers should not submit waiver requests for data elements for which the **payer exceeded** or **met** the edit threshold for the previous year's submission. Unless the payer has supporting documentation that their circumstances have changed, the Commission will only consider a waiver request regarding a data element which the payer fell below the threshold in the preceding year. Failure to consult the QRS in advance will result in the entire waiver request being returned.

- Submissions that do not meet the specific thresholds listed in the File Layouts Section (Appendix E, pg. 49) will be returned unless a waiver was obtained. (Note: If you cannot meet the minimum thresholds, you must request an exemption prior to submission.)

PROFESSIONAL SERVICES DATA REPORT –

- The Professional Services File – Control Total Verification – **Section 1. Source Company** (pg. 15), report the number of unique Patient IDs and number of services by Source Company type category, as derived from the submission file. Specify the total payment information for all Source Company types.

- The Professional Services File – Data Submission Documentation – **Section 2. Service Thru Date Frequency table** (pg. 15), if the Service Thru Date is not reported, then assume that the Service From Date and the Service Thru Date are the same.

- The Professional Services File – Control Total Verification – **Section 3. Coverage Type** (pg. 16), report the number of unique Patient IDs and number of services by Coverage Type category, as derived from the submission file. Specify the total payment information for all Coverage Types.

- The Professional Services File – Control Total Verification – **Section 4. Plan Liability** (pg. 17), report the number of unique Patient IDs and number of services by Plan Liability category, as derived from the submission file. Specify the total payment information for all Plan Liability categories.

- The Professional Services File – Control Total Verification – **Section 5. Participating Provider Status** (pg. 17), report the number of unique Patient IDs and number of services by Participating Provider category, as derived from the submission file. Specify the total payment information for all Participating Provider categories.

- The Professional Services File – Control Total Verification – **Section 6. Product Type** (pg. 18), report the number of unique Patient IDs and number of services by Product Type, as derived from the submission file. Specify the total payment information for all Product Type categories.

- The Professional Services File – Control Total Verification – **Section 7. Consumer Directed Health Plan Indicator** (pg. 18), report the number of unique Patient IDs and number of services by Consumer Directed Health Plan category, as derived from the submission file. Specify the total payment information for all Consumer Directed Health Plan categories.

- The Professional Services File – Control Total Verification – **Section 8. Record Status Description** (pg. 19), report the number of unique Patient IDs and number of services by Record Status, as derived from the submission file. Specify the total payment information for all Record Status categories.

- The Professional Services File – Data Submission Documentation – **Section 9. Homegrown Procedure Codes / Capitation Questions** (pg. 20) includes questions on the types of services reported that do not have payment information (capitated or global contract), and contracts with external provider networks.

- The Professional Services File Layout includes the **Servicing Practitioner Individual NPI Number**. This is in addition to the **Practitioner NPI Number used for Billing**.

- For the Professional Services File Layout, Variable Format, the **Date of Enrollment** and the **Date of Disenrollment** moved from the variable to the fixed segment of the record layout (pg. 52).

- **Patient Covered by Other Insurance Indicator** on the Professional Services Layout (field #8, pg. 50) and Institutional Services Layout (field #140, pg. 61). If you believe you are the **primary payer** then please code "0" (zero) in this field (pg. 65, pg. 89). MHCC is asking payers to pay special attention to coding this field as it is important in many analyses of interest to payers.

PHARMACY DATA REPORT –

- The Pharmacy File – Control Total Verification – **Section 2. National Drug Code (NDC)** (pg. 22), report the number of unique Patient IDs and number of prescriptions by National Drug Code, as derived from the submission file. Specify the total payment information for all Code Range categories.

- The **Source of Processing** (field #26, pg. 55) on the Pharmacy Data File indicates if the pharmacy claim was processed internally by the payer or by an outside pharmacy vendor.

- The **Prescription Fill Number** and **Date Prescription Written** on the Pharmacy Data File Layout indicate if the prescription is an original or refill, and the date the prescription was written.

- The Patient **Date of Enrollment** and **Date of Disenrollment** fields are included on the Pharmacy Data Report.

- The Pharmacy Data File Layout includes the **Prescribing Practitioner Individual National Provider Identifier (NPI) Number** (field #20, pg. 54, pg. 72).

PROVIDER DIRECTORY –

- The Provider Directory Report (pg. 56, pg. 78) includes the **Practitioner Organizational National Provider Identifier (NPI) Number**. *(Note: If the practice is a Multi-Practitioner Health Care Organization, then this field should be filled.)*

INSTITUTIONAL SERVICES DATA REPORT –

- The Institutional Services File – Control Total Verification – **Section 1. Type of Facility** (pg. 23), report the number of unique Patient IDs and number of discharges (hospital inpatient) or number of visits (hospital outpatient/non-hospital facility) as derived from the submission file. Specify the total payment information for all types of facilities.

- The Institutional Services File – Data Submission Documentation – **Section 2. Date of Discharge or End of Service** frequency table (pg. 23) includes columns for: Number (#) of Hospital Inpatient Discharges, and Number (#) of Hospital Outpatient or Non-hospital Visits for the reporting period. *(Note: If the Date of Discharge or End of Service date is not reported, then assume that the Date of Admission or Start of Service, and the Date of Discharge or End of Service are the same.)*

- The Institutional Services File – Control Total Verification – **Section 3. Record Status Description** (pg. 25), report the number of unique Patient IDs and number of services by Record Status, as derived from the submission file. Specify the total payment information for all Record Status categories.

MEDICAL ELIGIBILITY DATA REPORT –

- The Medical Eligibility File – Control Total Verification table – **Section 1. Coverage Type** (pg. 26), report the total number of **enrollees** and total number of **member months** by Coverage Type category.

- The Medical Eligibility File – Control Total Verification table – **Section 2. Product Type** (pg. 27), report the total number of **enrollees** and total number of **member months** by Product Type category.

- The Medical Eligibility File – Control Total Verification table – **Section 3. Plan Liability** (pg. 27), report the total number of **enrollees** and total number of **member months** by Plan Liability type.

- The Medical Eligibility File – Control Total Verification table – **Section 4. Source Company** (pg. 28), report the total number of **enrollees** and total number of **member months** by Source Company category.

- The Medical Eligibility File – Control Total Verification table – **Section 5. Consumer Directed Health Plan Indicator** (pg. 28), report the total number of **enrollees** and total number of **member months** by Consumer Directed Health Plan Indicator category.

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MEDICAL ELIGIBILITY DATA REPORT (cont.) –

- The Medical Eligibility File – Control Total Verification table – **Section 6. Policy Type** (pg. 29), report the total number of **enrollees** and total number of **member months** by Policy Type category.

- The Medical Eligibility File – Control Total Verification table – **Section 7. Number of Enrollees by Month** (pg. 29), report the number of enrollees (subscribers and dependents) covered under the plan, whether or not the enrollee received any covered services during the reporting year.

FORMATTING NOTES –

- **RIGHT** justify all NUMERIC fields *(Pharmacy NCPDP is the only numeric field that is "exclusively left justified).*

- **POPULATE** any NUMERIC field—except the financial fields for capitated/global contract services—for which you have no data to report with **ZEROS**.

- **Financial fields** for capitated or global contract services that lack data are to be filled with -999 (see page 34). If you have the patient liability information for these services, you must report the patient liability values, even though the other financial fields (billed charge, allowed amount, reimbursement amount) are lacking data.

- Leave **BLANK** the positions in NUMERIC fields for which the entry is less than the allowed field length.

- **DO NOT** add leading zeroes to amount/financial fields.

- **LEFT** justify all ALPHANUMERIC fields.

- Leave **BLANK** any ALPHANUMERIC fields for which you have no data to report.

MARYLAND HEALTH CARE COMMISSION

PAYER SUBMISSION AND DOCUMENTATION CHECKLIST

Please use this checklist as a guideline for your data submission.

	Item	Page #
☐	Professional Services Data Report Layout	50
☐	Pharmacy Data Report Layout	54
☐	Provider Directory Report Layout	56
☐	Institutional Services Data Report Layout	57
☐	Medical Eligibility Data Report Layout	62
☐	Payer ID# on all Media & Documentation	38
☐	Media Format/Transmission Information	39

In order to read your data, please include the necessary documentation:

☐	Copies of File Layouts	
☐	File Documentation – Section II (Excel workbook – MCDB File Documentation)	
☐	Data Element Documentation – Section III (Excel workbook – MCDB Element Documentation)	
☐	Place of Service Mapping	31
☐	Practitioner Specialty Mapping	34

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

MARYLAND HEALTH CARE COMMISSION

SECTION II

FILE DOCUMENTATION

[Excel workbook – MCDB File Documentation_022013]

- PROFESSIONAL SERVICES FILE
- PHARMACY FILE
- PROVIDER DIRECTORY
- INSTITUTIONAL SERVICES FILE
- MEDICAL ELIGIBILITY FILE

MARYLAND HEALTH CARE COMMISSION

MEDICAL CARE DATA BASE DOCUMENTATION FORM [Excel worksheet – Documentation_Form]

PAYER NAME (S):_____

PAYER ID #: _____ *(See Appendix A for a complete list of 2012 MCDB payers & Payer ID numbers)*

CONTACT NAME/TITLE: _____

ADDRESS: _____

PHONE NUMBER: _____ **FAX NUMBER:** _____ **E-MAIL ADDRESS:** _____

PROFESSIONAL SERVICES
MEDIA TYPE:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Records *(if variable format)*: _____
Blocking Factor: _____ Number of Services *(if fixed format)*: _____
Logical Record Length: _____

Fixed Format ☐ Variable Format ☐

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

PROVIDER DIRECTORY
MEDIA TYPE:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Records: _____
Blocking Factor: _____ Logical Record Length: _____

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

PHARMACY SERVICES
MEDIA TYPE:
☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Prescriptions:_____
Blocking Factor: _____ Logical Record Length:_____

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

INSTITUTIONAL SERVICES ☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
MEDIA TYPE: ☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Claims: _____

Blocking Factor: _____ Logical Record Length: _____

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

MEDICAL ELIGIBILITY FILE ☐ IBM 3480/3480E Cartridge ☐ IBM 3490/3490E Cartridge
MEDIA TYPE: ☐ CD-ROM/DVD ☐ DLT Tape IV
☐ Secure FTP

Number of Media: _____ Number of Enrollee Months: _____

Blocking Factor: _____ Logical Record Length: _____

Computer Operating System: _____ Recording Format: ASCII ☐ EBCDIC ☐

DATA SUBMISSION SOURCE SYSTEM

Please identify the **Source System** (platforms or business units) from which the data was obtained by using an alphabet letter indicating which system each letter represents. Leave the field **blank** if submitting data from **one (1) platform or business unit only.**

(Note: This information will allow the data base contractor to more efficiently identify the source of problems in a payer's submission.)

Label	**Source System** *(platform or business unit)*
A	
B	
C	
D	
E	

(Note: If using the Secure File Transfer Process (SFTP), please provide documentation with your SFTP transmission. If submitting a physical media please provide an electronic version of this documentation with the required keyable pages submission.)

Please forward physical media and accompanying documentation to:

Mr. Adrien Ndikumwami • Social & Scientific Systems, Inc. • 8757 Georgia Avenue, 12th Floor • Silver Spring, MD 20910

PROFESSIONAL SERVICES FILE – Data Submission Documentation

1. Professional Services Control Total Verification – SOURCE COMPANY
[Excel worksheet – ProfServ_Source_Company]

Please complete the following table by supplying the number of unique patient IDs and number of services by Source Company for the time period January 1, 2012 through December 31, 2012. Source Company is defined as the payer company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law. Specify the total payment information for all Source Company types.
Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

			Payment Information			
Source Company* [Value]	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
Health Maintenance Organization **[1]**						
Life & Health Insurance Company or Not-for-Profit Health Benefit Plan **[2]**						
Third Party Administrator (TPA) Unit **[3]**						
TOTAL			**$**	**$**	**$**	**$**

** Include Administrative Services Only (ASO) contracts under the Source Company under which they are sold.*
*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

2. SERVICE THRU DATE Frequency [Excel worksheet – ProfServ_Services_thru_Date]

Please complete the table below using the month and year segments for **Service Thru Date** (data element number 30 on the Professional Services **fixed** file layout). If the Service Thru Date is not reported, then assume that the Service From Date (data element number 29) and the Service Thru Date are the same. This table will provide an assessment of your data submission.

Service Thru Date Month/Year	# Services
Jan 2012	
Feb 2012	
Mar 2012	
Apr 2012	
May 2012	
Jun 2012	

Service Thru Date Month/Year	# Services
Jul 2012	
Aug 2012	
Sept 2012	
Oct 2012	
Nov 2012	
Dec 2012	

Service Thru Date Month/Year	# Services
Jan 2013	0
Feb 2013	0
Mar 2013	0
Apr 2013	0

A. Is this service volume distribution consistent with your experience?

☐ Yes ☐ **If no**, please explain _____

3. Professional Services Control Total Verification – COVERAGE TYPE
[Excel worksheet – ProfServ_Coverage_Type]

Please complete the following table by supplying the number of unique patient IDs and number of services by Coverage Type for the time period January 1, 2012 through December 31, 2012. Coverage Type indicates the enrollee's type of insurance coverage (i.e., individual market, Medigap, employer sponsored, etc.). Specify the total payment information for all Coverage Type categories.
Please compare this 2012 report to the 2011 MCDB Data Summary Worsheet.

(See Appendix C for plans that offer coverage in the various markets.)

			Payment Information			
Coverage Type [Value]	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
Medicare Supplemental [1] (i.e. Individual, Group, WRAP)						
Medicare Advantage Plan [2] (Health plan options that are part of the Medicare program)						
Individual Market [3] (not MHIP)						
Maryland Health Insurance Plan (MHIP) [4] (State-managed health insurance program for MD residents unable to obtain health insurance from other sources.)						
Private Employer Sponsored or Other Group [5] (i.e. union or association plans)						
Public Employee – Federal [6] (FEHBP)						
Public Employee – Other [7] (state, county, local/municipal government and public school systems)						
Comprehensive Standard Health Benefit Plan – [8] (except HIP) (Private or Public Employee) The CSHBP applies to small businesses (i.e., public or private employers) with 2 to 50 eligible employees or a self-employed individual.						
Health Insurance Partnership (HIP) [9] (State-subsidy to help MD small employers with 2 to 9 employees offer health insurance to their employees.)						
Student Health Plan [A] (A health plan offered to students at institutions of higher learning.)						
Unknown [Z]						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

4. Professional Services Control Total Verification – PLAN LIBILITY
[Excel worksheet – ProfServ_Plan_Liability]

Please complete the following table by supplying the number of unique patient IDs and number of services by Plan Liability for the time period January 1, 2012 through December 31, 2012. Plan Liability indicates if the insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO (Administrative Services Only). Specify the total payment information for all Plan Liability categories.
Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

			Payment Information			
Plan Liability Flag [Value]	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
Risk **[1]** (under Maryland contract)						
Risk **[2]** (under non-Maryland contract)						
ASO **[3]** (employer self-insured)						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

5. Professional Services Control Total Verification – PARTICIPATING PROVIDER STATUS
[Excel worksheet – ProfServ_ParProvider]

Please complete the following table by supplying the number of unique patient IDs and number of services by Participating Provider Status for the time period January 1, 2012 through December 31, 2012. Participating Provider status identifies if the service was provided by a provider that participates in the payer's network. Please document why you cannot identify whether a provider does or does not participate. Specify the total payment information for all Participating Provider categories.
Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

			Payment Information			
Participating Provider Status [Value]	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
Participating **[1]**						
Non-Participating **[2]**						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

6. Professional Services Control Total Verification – PRODUCT TYPE [Excel worksheet – ProfServ_Product_Type]

Please complete the following table by supplying the number of unique patient IDs and number of services by Product Type for the time period January 1, 2012 through December 31, 2012. Product Type classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). Please select category based on how the product is primarily marketed. Specify the total payment information for all Product Type categories.
Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

			Payment Information			
Product Type [Value]	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
Exclusive Provider Organization **[1]** *(in any form)*						
Health Maintenance Organization **[2]**						
Indemnity **[3]**						
Point of Service (POS) **[4]**						
Preferred Provider Organization (PPO) **[5]**						
Limited Benefit Plan (Mini-Meds) **[6]**						
Student Health Plan **[7]**						
Catastrophic **[8]**						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

7. Professional Services Control Total Verification – CONSUMER DIRECTED HEALTH PLAN INDICATOR (0,1) – [Excel worksheet – ProfServ_CDHP]

Please complete the following table by supplying the number of unique patient IDs and number of services by Consumer Directed Health Plan Indicator for the time period January 1, 2012 through December 31, 2012. A "1" indicates a Consumer Directed Health Plan with a Health Savings Account (HSA) or Health Resources Account (HRA). Specify the total payment information for all Consumer Directed Health Plan Indicator categories.
Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

			Payment Information			
Consumer Directed Health Plan Indicator [Value]	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
No [0]						
Yes [1]						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

8. Professional Services File – RECORD STATUS [Excel worksheet – ProfServ_Record_Status]

NOTE: **Capitated** or **Global Contract services on the Professional Services File** are also identified as services where at least three financial variables (billed charge, allowed amount, and reimbursement amount) are equal to **–999**. **Patient deductible, patient coinsurance/co-payment, and other patient obligations must be reported when available.**

MUST SUBMIT IN REQUIRED FORMAT *(see below)*

Value	Label	Definition
1	**Final Bill**	Total adjusted amount of all credits and debits paid for a claim by the insurance company to the provider.
8	**Capitated or Global Contract Services**	Set of pre-defined services provided by the provider to the plan's enrollees under contract with an insurance company or managed care plan in exchange for a fixed and guaranteed monthly payment for each enrollee assigned to the provider, or reimbursed through a global contract with an intermediary organization.

Instructions: Identify record status in the column provided. Please complete the following table by supplying the number of unique patient IDs and number of services by Record Status Description for the time period January 1, 2012 through December 31, 2012. Specify the total payment information for all Record Status categories.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

			Payment Information			
Record Status Description [Value]	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
Final Bill [1]						
Capitated or Global Contract Services [8]						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

9. Homegrown Procedure Codes/Capitation Questions
[Excel worksheet – ProfServ_Homegrown_Capitation]

A. Does this data submission include homegrown procedure codes*?

☐ No ☐ **If yes**, please provide in a separate electronic file a list of codes and definitions applicable to this submission.

** Note: Submissions that do not meet the 95% threshold for this variable will be returned unless the payer has obtained a waiver.*

* If your company is not a Staff Model Health Maintenance Organization (HMO), please answer the following:

B. What types of services in your data submission do not have payment information (billed charge, allowed amount, reimbursement amount) because they are capitated or reimbursed through a global contract with an intermediary organization?

	Health **M**aintenance **O**rganization		**P**referred **P**rovider **O**rganization
	Capitated	Global contract	Global contract
Primary Care	☐	☐	☐
Specialty Care	☐	☐	☐
Mental Health Services	☐	☐	☐
Physical Therapy Services	☐	☐	☐
Laboratory Services	☐	☐	☐
Radiology Services	☐	☐	☐
Optometry Services	☐	☐	☐
Other (specify) _____	☐	☐	☐

If a health maintenance organization (HMO) is not one of your product lines, and you are providing capitated services, please explain. (attach additional sheets if needed)

_____

C. Does your organization contract with an "external provider network" to serve your enrolled population in Maryland? [Excel worksheet – ProfServ_External_Prov_Network]

☐ No ☐ **If yes,** please indicate all networks under contract.

☐ ChoiceCare Network ☐ Integrated Health Plan, Inc. (IHP) ☐ PlanCare America

☐ Devin Health Services, Inc. ☐ MultiPlan Network ☐ United Healthcare

☐ First Health Network ☐ OneNet PPO Network ☐ UnitedHealthOne

☐ Galaxy Health Network ☐ PHCS PPO Network ☐ USA Health & Wellness Network

☐ Other (specify) _____

10. Anesthesia Services [Excel worksheet – ProfServ_Anesthesia]

Restrict to: CPT 00100-01999
99100-99140

Value	Service Unit Indicator	# Services	# Units
2	Anesthesia Time Units *		
8	Minutes of Anesthesia *		
1	Transportation (ambulance air or ground) miles		
3	Services		
4	Oxygen Units		
5	Units of Blood		
6	Allergy Tests		
7	Laboratory Tests		

** Note: For Anesthesia Services, we would expect the Service Unit Indicator to have a value of "2" or "8".*

A. Are base units included in the units field for these services?

☐ Yes ☐ No

B. Are anesthesia units associated with physical status modifiers counted when anesthesia payments are calculated?

(Physical status modifiers are used by some payers to compensate anesthesiology providers when the patient is very young, old, or frail. The modifiers are reported in the CPT modifier field.)

☐ Yes ☐ No

If yes, please supply the additional anesthesia units in the table below.

Physical Status Modifiers	Anesthesia Units
P1 – A normal healthy patient.	0
P2 – A patient with mild systemic disease.	
P3 – A patient with severe systemic disease.	
P4 – A patient with severe systemic disease that is a constant threat to life.	
P5 – A moribund patient who is not expected to survive without the operation.	
P6 – A declared brain-dead patient whose organs are being removed for donor purposes.	

PHARMACY FILE – Data Submission Documentation

1. Date Filled Frequency (Pharmacy) [Excel worksheet – Pharmacy_Date_Filled]

Please complete the table below using the month and year segments for **Date Filled** (data element number 15 on the file layout). This table will provide an assessment of your data submission.

Month/Year	# Prescriptions
Jan 2012	
Feb 2012	
Mar 2012	
Apr 2012	
May 2012	
Jun 2012	
Jul 2012	
Aug 2012	

Month/Year	# Prescriptions
Sep 2012	
Oct 2012	
Nov 2012	
Dec 2012	
Jan 2013	0
Feb 2013	0
Mar 2013	0
Apr 2013	0

2. National Drug Code (NDC) [Excel worksheet – Pharmacy_NDC]

Please complete the following table by supplying the number of unique patient IDs and number of prescriptions by Prescription Code Range for the time period January 1, 2012 through December 31, 2012. Provide a total for NDC and all non-coded drugs. All remaining drug code totals should be summed under "Not National Drug Codes." Specify the total payment information for all Code Range categories.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

			Payment Information			
Code Range	**# Unique Patient IDs**	**# Prescriptions**	**Billed Charge**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+Patient)**
NDC						
Not Coded						
NOT National Drug Codes						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

Comments:_____

3. Mail Order Pharmacy Information [Excel worksheet – Pharmacy_Mail_Order]

Mail Order Pharmacy NCPDP#	Name of Pharmacy

Note: *Attach additional sheets if needed or provide a separate electronic file.*

INSTITUTIONAL SERVICES FILE – Data Submission Documentation

1. Institutional Services Control Total Verification – TYPE OF FACILITY
[Excel worksheet – InstServ_Facility_Type]

Please complete the following table by supplying the number of unique patient IDs and number of discharges or visits by Type of Facility for the time period January 1, 2012 through December 31, 2012, as derived from the submission file to be used as a true control. Specify the total payment information for all types of facilities. **Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.**

			Payment Information			
Type of Facility *(see page 24)*	**# Unique Patient IDs**	**# Discharges** (Hospital Inpatient) or **# Visits** (Hospital Outpatient /Non-Hospital facility)	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid** (Insurer+Patient)
Hospital Inpatient						
Hospital Outpatient						
Non-Hospital Facility						
TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

2. DATE OF DISCHARGE or END OF SERVICE Frequency
[Excel worksheet – InstServ_Date_Discharge]

Please complete the table below using the month and year segments for **Date of Discharge or End of Service** (data element number 19 on the Institutional Services file layout). If the Date of Discharge or End of Service date is not reported, then assume that the Date of Admission or Start of Service (data element number 18) and the Date of Discharge or End of Service are the same. This table will provide an assessment of your data submission.

Month/Year	# Hospital Inpatient Discharges	# Hospital Outpatient / Non-Hospital Visits
Jan 2012		
Feb 2012		
Mar 2012		
Apr 2012		
May 2012		
Jun 2012		
Jul 2012		
Aug 2012		

Month/Year	# Hospital Inpatient Discharges	# Hospital Outpatient / Non-Hospital Visits
Sept 2012		
Oct 2012		
Nov 2012		
Dec 2012		
Jan 2013	0	0
Feb 2013	0	0
Mar 2013	0	0
Apr 2013	0	0

A. Is this service volume distribution consistent with your experience?

☐ Yes ☐ **If no**, please explain _____

INSTITUTIONAL SERVICES FILE – Data Submission Documentation – Facility Type Crosswalk

The table below represents a crosswalk for the **Type of Facility** categories listed in Table 1. Institutional Services Control Total Verification *(pg. 23)* with the first 2 digits of the three-digit **Type of Bill** field categories listed on page 85 of the submission manual. This crosswalk of codes is based on Bill Type codes reported in the CMS Medicare Claims Processing Manual.

TYPE of FACILITY	TYPE OF BILL (Type of Facility + Bill Classification)
Hospital Inpatient	11 – Hospital Inpatient *(including Medicare Part A)*
	12 – Hospital Inpatient *(including Medicare Part B only)*
	18 – Hospital Swing Beds
	21 – Skilled Nursing Facility Inpatient *(including Medicare Part A)*
	22 – Skilled Nursing Facility Inpatient *(including Medicare Part B only)*
	28 – Skilled Nursing Facility Swing Beds
	41 – Christian Science Hospital Inpatient *(including Medicare Part A)*
	42 – Christian Science Hospital Inpatient *(including Medicare Part B only)*
	48 – Christian Science Hospital Swing Beds
Hospital Outpatient	13 – Hospital Outpatient
	14 – Hospital Other *(for hospital referenced diagnostic services or home health not under a plan of treatment)*
	23 – Skilled Nursing Facility Outpatient
	24 – Skilled Nursing Facility Other *(for hospital referenced diagnostic services)*
	43 – Christian Science Hospital Outpatient
	44 – Christian Science Hospital Other *(for hospital referenced diagnostic services or home health not under a plan of treatment)*
	72 – Clinic, Hospital-based or Independent Renal Dialysis
Non-Hospital Facility	ALL OTHER first 2-digit combinations

3. Institutional Services File – RECORD STATUS *(from Type of Bill 3rd digit)* [Excel worksheet – InstServ_Record_Status]

Record Status: On the Institutional Services File, this data field will be determined using the third digit in the Type of Bill field. Identify Record Status in the column provided.

Please complete the following table by supplying the number of unique patient IDs and number of services by Record Status Description for the time period January 1, 2012 through December 31, 2012. Specify the total payment information for all Record Status categories.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

				Payment Information			
Values	**Third digit Label**	**# Unique Patient IDs**	**# Services**	**Total Allowed Amount**	**Total Patient Liability****	**Total Insurer Reimbursement Amount**	**Total Amount Paid (Insurer+ Patient)**
1	**Admit through Discharge**						
2,3,4	**Interim – First Claim Used Interim – Continuing Claims Interim – Last Claim**						
5	**Late Charge Only**						
6	**Adjustment of Prior Claim**						
7	**Replacement of Prior Claim**						
8	**Void/Cancel of Prior Claim**						
	TOTAL			**$**	**$**	**$**	**$**

*** Total patient liability is equal to the sum of patient deductible, patient coinsurance/copayment, and other patient obligations.*

MEDICAL ELIGIBILITY FILE – Data Submission Documentation

1. Medical Eligibility Control Total Verification – COVERAGE TYPE

[Excel worksheet – MedElig_Coverage_Type]

Please complete the table below by supplying the number of enrollees and number of member months by Coverage Type for the time period January 1, 2012 through December 31, 2012.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

Coverage Type	Value	# Enrollees	# Member Months
Medicare Supplemental (i.e. Individual, Group, WRAP)	1		
Medicare Advantage Plan (Health plan options that are part of the Medicare program)	2		
Individual Market (not MHIP)	3		
Maryland Health Insurance Plan (MHIP) (State-managed health insurance program for MD residents unable to obtain health insurance from other sources.)	4		
Private Employer Sponsored or Other Group (i.e. union or association plans)	5		
Public Employee – Federal (FEHBP)	6		
Public Employee – Other (state, county, local/municipal government and public school systems)	7		
Comprehensive Standard Health Benefit Plan – (except HIP) (Private or Public Employee) The CSHBP applies to small businesses (i.e., public or private employers) with 2 to 50 eligible employees or a self-employed individual.	8		
Health Insurance Partnership (HIP) (State-subsidy to help MD small employers with 2 to 9 employees offer health insurance to their employees.)	9		
Student Health Plan (A health plan offered to students at institutions of higher learning.)	A		
Unknown	Z		
TOTAL			

2. Medical Eligibility Control Total Verification – PRODUCT TYPE
[Excel worksheet – MedElig_Product_Type]

Please complete the table below by supplying the number of enrollees and number of member months by Product Type for the time period January 1, 2012 through December 31, 2012.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

Product Types	Value	# Enrollees	# Member Months
Exclusive Provider Organization *(in any form)*	1		
Health Maintenance Organization	2		
Indemnity	3		
Point of Service (POS)	4		
Preferred Provider Organization (PPO)	5		
Limited Benefit Plan (Mini-Meds)	6		
Student Health Plan	7		
Catastrophic	8		
TOTAL			

3. Medical Eligibility Control Total Verification – PLAN LIABILITY
[Excel worksheet – MedElig_Plan_Liability]

Please complete the table below by supplying the number of enrollees and number of member months by Plan Liability for the time period January 1, 2012 through December 31, 2012.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

Plan Liability Flag		# Enrollees	# Member Months
Risk (under Maryland contract)	1		
Risk (under non-Maryland contract)	2		
ASO (employer self-insured)	3		
TOTAL			

4. Medical Eligibility Control Total Verification – SOURCE COMPANY [Excel worksheet – MedElig_Source_Company]

Please complete the table below by supplying the number of enrollees and number of member months by Source Company for the time period January 1, 2012 through December 31, 2012.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

Source Company*	Value	# Enrollees	# Member Months
Health Maintenance Organization	1		
Life & Health Insurance Company or Not-for-Profit Health Benefit Plan	2		
Third Party Administrator (TPA) Unit	3		
TOTAL			

** Include Administrative Services Only (ASO) contracts under the Source Company that holds the contract.*

5. Medical Eligibility Control Total Verification – CONSUMER DIRECTED HEALTH PLAN INDICATOR (0,1) – [Excel worksheet – MedElig_CDHP]

Please complete the table below by supplying the number of enrollees and number of member months by Consumer Directed Health Plan Indicator for the time period January 1, 2012 through December 31, 2012.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

Consumer Directed Health Plan Indicator	Value	# Enrollees	# Member Months
No	0		
Yes	1		
TOTAL			

6. Medical Eligibility Control Total Verification – POLICY TYPE
[Excel worksheet – MedElig_Policy_Type]

Please complete the table below by supplying the number of enrollees and number of member months by Type of Policy for the time period January 1, 2012 through December 31, 2012.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

Type of Policy	Value	# Enrollees	# Member Months
Individual	1		
Any combination of two or more persons	2		
TOTAL			

7. Medical Eligibility Control Total Verification – Number of ENROLLEES by Month
[Excel worksheet – MedElig_Enrollees_Month]

Please complete the table below by supplying the number of enrollees by month and year. This table will provide an assessment of your submission.

Please compare this 2012 report to the 2011 MCDB Data Summary Worksheet.

Month/Year	# Enrollees
Jan 2012	
Feb 2012	
Mar 2012	
Apr 2012	
May 2012	
Jun 2012	
Jul 2012	
Aug 2012	

Month/Year	# Enrollees
Sep 2012	
Oct 2012	
Nov 2012	
Dec 2012	
Jan 2013	0
Feb 2013	0
Mar 2013	0
Apr 2013	0

MARYLAND HEALTH CARE COMMISSION

SECTION III

DATA ELEMENT DOCUMENTATION

[Excel workbook – MCDB Data Element Documentation_022013]

- PLACE OF SERVICE
- PRACTITIONER SPECIALTY

PLACE OF SERVICE [Excel worksheet – DED_Place_Service]

Place of Service: The setting in which a health care service was provided. Definitions provided on pages 32 & 33.

Instructions: In the description column, please describe the values as mapped from your system **and** indicate the number of services in your Professional Services data set.

CMS/HIPAA Information			
Place of Service	**Value**	**Description** (describe values mapped from payer system)	**# Services**
Provider's Office	11		
Patient's Home	12		
Assisted Living Facility	13		
Walk-in Retail Health Clinic New!	**17**		
Urgent Care Facility – please code appropriately	20		
Inpatient Hospital	21		
Outpatient Hospital	22		
Emergency Room – Hospital	23		
Ambulatory Surgical Center	24		
Birthing Center	25		
Military Treatment Facility	26		
Skilled Nursing Facility	31		
Nursing Facility	32		
Custodial Care Facility	33		
Hospice	34		
Ambulance – Land	41		
Ambulance – Air or Water	42		
Inpatient Psychiatric Facility	51		
Psychiatric Facility – Partial Hospitalization	52		
Community Mental Health Center	53		
Intermediate Care Facility/Mentally Retarded	54		
Residential Substance Abuse Treatment Facility	55		
Psychiatric Residential Treatment Center	56		
Non-residential Substance Abuse Treatment Facility	57		
Mass Immunization Center	60		
Comprehensive Inpatient Rehabilitation Facility	61		
Comprehensive Outpatient Rehabilitation Facility	62		
End-Stage Renal Disease Treatment Facility	65		
State or Local Public Health Clinic	71		
Rural Health Clinic	72		
Independent Laboratory & Imaging	81		
Other Place of Service	99		

Place of Service Codes for Professional Claims

Centers for Medicare & Medicaid Services (CMS)

CMS – Code	Place of Service	Description
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
13	Assisted Living Facility	Congregate residential facility with self-contained living units providing assessment of each resident's needs and on-site support 24 hours a day, 7 days a week, with the capacity to deliver or arrange for services including some health care and other services.
17	**Walk-in Retail Health Clinic**	A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic and not described by any other Place of Service code, that is located within a retail operation and provides, on an ambulatory basis, preventive and primary care services.
20	Urgent Care Facility	Location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.
21	Inpatient Hospital	A facility, other than psychiatric, which primarily provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services by, or under, the supervision of physicians to patients admitted for a variety of medical conditions.
22	Outpatient Hospital	A portion of a hospital which provides diagnostic, therapeutic (both surgical and non-surgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
23	Emergency Room – Hospital	A portion of a hospital where emergency diagnosis and treatment of illness or injury is provided.
24	Ambulatory Surgical Center	A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
25	Birthing Center	A facility, other than a hospital's maternity facilities or a physician's office, which provides a setting for labor, delivery, and immediate post-partum care as well as immediate care of new born infants.
26	Military Treatment Facility	A medical facility operated by one or more of the Uniformed Services. Military Treatment Facility (MTF) also refers to certain former U.S. Public Health Service (USPHS) facilities now designated as Uniformed Service Treatment Facilities (USTF).
31	Skilled Nursing Facility	A facility which primarily provides inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital.
32	Nursing Facility	A facility which primarily provides to residents skilled nursing care and related services for the rehabilitation of injured, disabled, or sick persons, or, on a regular basis, health-related care services above the level of custodial care to other than mentally retarded individuals.
33	Custodial Care Facility	A facility which provides room, board and other personal assistance services, generally on a long-term basis, and which does not include a medical component.
34	Hospice	A facility, other than a patient's home, in which palliative and supportive care for terminally ill patients and their families are provided.
41	Ambulance – Land	A land vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
42	Ambulance – Air or Water	An air or water vehicle specifically designed, equipped and staffed for lifesaving and transporting the sick or injured.
51	Inpatient Psychiatric Facility	A facility that provides inpatient psychiatric services for the diagnosis and treatment of mental illness on a 24-hour basis, by or under the supervision of a physician.

52	Psychiatric Facility - Partial Hospitalization	A facility for the diagnosis and treatment of mental illness that provides a planned therapeutic program for patients who do not require full time hospitalization, but who need broader programs than are possible from outpatient visits to a hospital-based or hospital-affiliated facility.
53	Community Mental Health Center	A facility that provides the following services: outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically ill, and residents of the CMHC's mental health services area who have been discharged from inpatient treatment at a mental health facility; 24 hour a day emergency care services; day treatment, other partial hospitalization services, or psychosocial rehabilitation services; screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission; and consultation and education services.
54	Intermediate Care Facility/Mentally Retarded	A facility which primarily provides health-related care and services above the level of custodial care to mentally retarded individuals but does not provide the level of care or treatment available in a hospital or SNF.
55	Residential Substance Abuse Treatment Facility	A facility which provides treatment for substance (alcohol and drug) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.
56	Psychiatric Residential Treatment Center	A facility or distinct part of a facility for psychiatric care which provides a total 24-hour therapeutically planned and professionally staffed group living and learning environment.
57	Non-residential Substance Abuse Treatment Facility	A location which provides treatment for substance (alcohol and drug) abuse on an ambulatory basis. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, and psychological testing.
60	Mass Immunization Center	A location where providers administer pneumococcal pneumonia and influenza virus vaccinations and submit these services as electronic media claims, paper claims, or using the roster billing method. This generally takes place in a mass immunization setting, such as, a public health center, pharmacy, or mall but may include a physician office setting.
61	Comprehensive Inpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to inpatients with physical disabilities. Services include physical therapy, occupational therapy, speech pathology, social or psychological services, and orthotics and prosthetics services.
62	Comprehensive Outpatient Rehabilitation Facility	A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
65	End-Stage Renal Disease Treatment Facility	A facility other than a hospital, which provides dialysis treatment, maintenance, and/or training to patients or caregivers on an ambulatory or home-care basis.
71	State or Local Public Health Clinic	A facility maintained by either State or local health departments that provides ambulatory primary medical care under the general direction of a physician.
72	Rural Health Clinic	A certified facility which is located in a rural medically underserved area that provides ambulatory primary medical care under the general direction of a physician.
81	Independent Laboratory	A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.
99	Other Place of Service	Other place of service not identified above.

PRACTITIONER SPECIALTY [Excel worksheet – DED_Prac Specialty]

Practitioner Specialty: The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified.

Instructions: In the description column, please list the payer specialty description(s) mapped to the COMAR defined specialties (more than one specialty can map to a COMAR defined specialty). Please indicate the number of services in your Professional Services data set that link to those specialties in the Provider Directory file.
(See Appendix C for examples of practitioner specialty expansions and/or consolidations.)

Physicians: (This list is not all inclusive.)

◆ **Indicates specialty listed alphabetically and numerically.**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
General Practice	001		
General Surgery	002		
Allergy & Immunology	003		
Anesthesiology	004		
Cardiology	005		
Dermatology	006		
Emergency Medicine	007		
Endocrinology Medicine	008		
Family Practice	009		
Gastroenterology	010		
Geriatrics	011		
Hand Surgery	012		
Hematology	013		
Internal Medicine	014		
Infectious Disease	015		
Multi-Specialty Medical Practice ◆	101		
Nephrology	016		
Neonatology ◆	100		
Neurology	017		
Nuclear Medicine	018		
Obstetrics/Gynecology ◆	039		
Oncology	019		
Ophthalmology	020		

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Orthopedic Surgery	021		
Osteopathy (include Manipulations)	022		
Otology, Laryngology, Rhinology, Otolaryngology	023		
Pathology	024		
Pediatrics	025		
Peripheral Vascular Disease or Surgery	026		
Plastic Surgery	027		
Physical Medicine and Rehabilitation	028		
Proctology	029		
Psychiatry	030		
Pulmonary Disease	031		
Radiology	032		
Rheumatology	033		
Surgical Specialty Not Listed Here	034		
Thoracic Surgery	035		
Urology	036		
Other Specialties not listed (public health, industrial medicine)	037		
Physician w/o Specialty Identified & Specialty not listed here	038		
Obstetrics/Gynecology ◆	039		
Neonatology ◆	100		
Multi-Specialty Medical Practice ◆	101		

◆ **Indicates specialty listed alphabetically and numerically.**

Other Health Care Professionals: **(This list is not all inclusive.)**
[Excel worksheet – DED_Other HC Prof]

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Acupuncturist	040		
Alcohol/Drug Detox Services	041		
Ambulance Services	042		
Audiologist/Speech Pathologist	043		
Chiropractor	044		
Freestanding Clinic (Not a Government Agency)	045		
Day Care Facility (Medical, Mental Health)	046		
Dietitian/Licensed Nutritionist	047		
Home Health Provider	048		
Mental Health Clinic ◆	102		
Advanced Practice Nurse: Anesthetist	049		
Advanced Practice Nurse: Midwife	050		
Advanced Practice Nurse: Nurse Practitioner	051		
Advanced Practice Nurse: Psychotherapist	052		
Nurse – Other than Advanced Practice	053		
Occupational Therapist	054		
Optometrist	055		
Podiatrist	056		
Physical Therapist	057		
Psychologist	058		
Clinical Social Worker	059		
Public Health or Welfare Agency (federal, state and local government)	060		
Voluntary Health Agency	061		
Other Specialty (Not Listed)	062		
Respiratory Therapist	063		
Physician Assistant	064		
Mental Health Clinic ◆	102		

◆ **Indicates specialty listed alphabetically and numerically.**

Dental: **(This list is not all inclusive.)** **[Excel worksheet – DED_Dental Prof]**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
General Dentist	070		
Endodontist	071		
Orthodontist	072		
Oral Surgeon	073		
Pedodontist	074		
Periodontist	075		
Prosthodontist	076		

Office Facilities: **(This list is not all inclusive.)** **[Excel worksheet – DED_Office Facilities]**

COMAR Information			
Practitioner Specialty	**Value**	**Description** (payer specialty descriptions mapped to COMAR defined specialties)	**# Services**
Freestanding Pharmacy (includes grocery stores)	080		
Mail Order Pharmacy	081		
Independent Laboratory	082		
Independent Medical Supply Company	083		
Optician/Optometrist (for lenses and eye glasses)	084		
Please specify whether using professional services or supplier codes for the following:			
All Other Supplies	085		
Freestanding Medical Facility	090		
Freestanding Surgical Facility	091		
Freestanding Imaging Center	092		
Other Facility	093		

APPENDIX A

2012 MCDB PAYERS & PAYER ID NUMBERS

(DATA DUE JUNE 30, 2013)

ORGANIZATION	Payer ID #	ORGANIZATION	Payer ID #
Aetna Health, Inc.	P030	Assurant Health/Time Insurance Co.	P280
Aetna Life Insurance Co.	P020	Golden Rule Insurance Co.	P320
American Republic Insurance Co.	P070	Kaiser Permanente Mid-Atlantic States	P480
CareFirst BlueChoice, Inc.	P130	MAMSI Life and Health Ins. Co.	P500
CareFirst of Maryland, Inc.	P131	MD-Individual Practice Association, Inc.	P520
Group Hospitalization & Medical Services, Inc. (GHMSI)	P132	MEGA Life & Health Insurance Co.	P530
CIGNA Healthcare Mid-Atlantic, Inc.	P160	Optimum Choice, Inc.	P620
Connecticut General Life Ins. Co.	P180	State Farm Mutual Automobile Ins. Co.	P760
Corporate Health Insurance Co.	P220	United Healthcare Insurance Co.	P820
Coventry Healthcare of Delaware, Inc.	P680	United Healthcare of the Mid-Atlantic, Inc.	P870

APPENDIX B

MEDIA FORMAT/TRANSMISSION INFORMATION

(Please label all media & documentation with your Payer ID # listed on page 36)

Secure SFTP Server

Payers have the ability to upload MCDB data files directly to the MHCC Secure SFTP site. If you would like to use this submission option, please contact Mr. Marty Teramani at (410) 764-3384 or via e-mail at marty.teramani@maryland.gov.

CD-ROM/DVD

Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC

IBM 3480/3480E or 3490/3490E Cartridge

Block Size:	16,000 bytes minimum, 32,760 bytes maximum
Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC
Labels:	Standard IBM labels preferred
Media:	3480/3480E or 3490/3490E Cartridge
Density:	3480/3480E or 3490/3490E Cartridge – default density

DLT Tape IV

Block Size:	16,000 bytes minimum, 32,760 bytes maximum
Record Type:	Fixed (preferred) or Variable length records
Recording Format:	ASCII or EBCDIC
Media:	DLT using dd or TAR commands
Density:	1600 BPI

APPENDIX B (cont.)

Secure SFTP Server Information

For payers submitting the MCDB data files directly to the **MHCC Secure FTP site**, the **Internet Protocol (IP) Address** for the SFTP server is **184.80.193.37**. Note that your company's assigned User ID and Password remain the same.

If your company intends to submit the 2012 Medical Care Data Base (MCDB) files via the Commission's secure FTP, the following naming convention is in effect for the five data reports. The indicators are separated by the _ (underscore) symbol: **PayerID_File_Version_Date**

Payer ID:	Appendix A assigned ID number
Files:	Professional Services Data Report = ProfServ Pharmacy Data Report = Pharm Provider Directory Report = Prov Institutional Services Data Report = InstServ Medical Eligibility Data Report = MedElig
Version:	Submission order *(Note: If the submission is returned, the following sequence should be incremented by one letter in the alphabet.)*
Date:	Month/Day/Year = MMDDYY
Example:	P123_ProfServ_A_063013 P123_ProfServ_B_071613 P123_ProfServ_C_073013 P123_Pharm_A_063013 P123_Pharm_B_071613 P123_Pharm_C_073013 P123_Prov_A_063013 P123_Prov_B_071613 P123_Prov_C_073013 P123_InstServ_A_063013 P123_InstServ_B_071613 P123_InstServ_C_073013 P123_MedElig_A_063013 P123_MedElig_B_071613 P123_MedElig_C_073013

MARYLAND HEALTH CARE COMMISSION

APPENDIX C

Explanation of Key Data Elements

- **COVERAGE TYPE**
- **PRACTITIONER SPECIALTY**
- **UNIVERSALLY UNIQUE IDENTIFIER (UUID)**

COVERAGE TYPE

Coverage Type: The data field that indicates type of insurance coverage (i.e., individual market, Medigap, employer sponsored, etc.).The following table lists COMAR Coverage Types and provides a column of mapping examples.

COMAR Coverage Type	Value	Examples of Coverage Type
Medicare Supplemental (i.e. Individual, Group, WRAP)	1	If your company provides Medicare Supplemental Insurance (Medigap)
Medicare Advantage Plan	2	• Medicare Health Maintenance Organization (HMOs) • Preferred Provider Organization (PPO) • Private Fee-for-Service Plans • Medicare Special Needs Plans • Medicare Medical Savings Account Plans (MSA)
Individual Market (not MHIP)	3	Most plans offer: • Conversion High • Conversion Standard • Direct Pay High • Direct Pay Standard
Maryland Health Insurance Plan (MHIP)	4	• CareFirst of Maryland, Inc. • CareFirst BlueChoice, Inc.
Private Employer Sponsored or Other Group (i.e., union or association plans)	5	If your company is providing either administrative services only or standard insurance to an employer or other group in the private sector: • Commercial Basic • Commercial High • Commercial Standard • Preferred Provider Option • Triple Option • HMO • Point of Service • Triple Option HMO • Indemnity • Triple Option POS • Triple Option PPO
Public Employee - Federal	6	If your company participates in the Federal Employees Health Benefits Program
Public Employee - Other	7	If your company is providing either administrative services only or standard insurance to an employer or other group in the public sector including state, county, local/municipal government, or public school systems
Comprehensive Standard Health Benefit Plan (except HIP)	8	Participating carriers: • Aetna Life Insurance Co. • Aetna Health Inc. • CareFirst BlueChoice, Inc. • CareFirst of MD, Inc. • Coventry Life & Health, Inc. • Coventry Healthcare DE, Inc. • Group Hospitalization & Medical Services • Kaiser Permanente Mid-Atlantic States • MAMSI Life and Health Insurance Company • MEGA Life & Health Insurance Company • Optimum Choice, Inc. • United Healthcare Insurance Company
Health Insurance Partnership (HIP)	9	Participating carriers: • Aetna Health Inc. • Coventry Life & Health, Inc. • CareFirst of MD, Inc. • United Healthcare Ins. Co.
Student Health Plan (A health plan offered to students at institutions of higher learning.)	A	Participating carriers: • Aetna Health Inc. • MEGA Life & Health Ins. Co. • CareFirst of MD, Inc. • United Healthcare Ins. Co.

PRACTTITONER SPECIALTY

Expansions/Consolidations

Practitioner Specialty: The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified.

(The following table shows examples where a practitioner specialty may encompass other services and is for illustrative purposes only.)

This list is <u>not</u> all inclusive.

Practitioner Specialty	Value	Specialties Not Specifically Identified	
General Practice	001		
General Surgery	002		
Allergy & Immunology	003	Pediatric Allergy & Immunology	
Anesthesiology	004		
Cardiology	005	Pediatric Cardiology	
Dermatology	006	Dermatopathology	
Emergency Medicine	007		
Endocrinology Medicine	008	Pediatric Endocrinology	
Family Practice	009		
Gastroenterology	010	Pediatric Gastroenterology	
Geriatrics	011		
Hand Surgery	012		
Hematology	013	Pediatric Hematology/Oncology	
Internal Medicine	014	Adolescent Medicine	
Infectious Disease	015	Pediatric Infectious Disease	
Multi-Specialty Medical Practice	101	Use this code only where provider-specific identifiers are not available for physicians practicing as a group with varying specialties.	
Nephrology	016	Pediatric Nephrology	
Neonatology	100		
Neurology	017	Pediatric Neurology	
Nuclear Medicine	018		
Obstetrics/Gynecology	039		
Oncology	019	Gynecological Oncology	
Ophthalmology	020	Pediatric Ophthalmology	
Orthopedic Surgery	021	Pediatric Orthopedic Surgery	
Osteopathy	022	Include manipulations	
Otology, Laryngology, Rhinology, Otolaryngology	023		
Pathology	024	Forensic Pathology Oral Pathology	
Pediatrics	025		
Peripheral Vascular Disease/Surgery	026		
Plastic Surgery	027	Reconstructive Surgery Cosmetic Surgery	
Physical Medicine and Rehabilitation	028	Rehabilitative Sports Medicine	
Proctology	029	Colon & Rectal Surgery	
Psychiatry	030	Pediatric Psychiatry	
Pulmonary Disease	031	Pediatric Pulmonary Medicine	
Radiology	032	MRI Nuclear Radiology Pediatric Radiology	
Rheumatology	033		
Surgical Specialty Not Listed Here	034	Abdominal Surgery Head and Neck Surgery Maxillofacial Surgery	Neurological Surgery Pediatric Surgery Vascular Surgery

Practitioner Specialty	Value	Specialties Not Specifically Identified	
Thoracic Surgery	035	Cardiovascular Surgery Thoracic Surgery	
Urology	036	Urology Pediatric Urology	
Other Specialties Not Listed	037	Public Health Industrial Medicine	
Physician without a Specialty Identified and Specialty Not Listed Here	038	• Addiction Medicine • Algology/Pain Management • Aerospace Medicine • Critical Care Medicine • Genetics • Infertility	• Multiple Specialty Physician Group • Occupational Medicine • Preventative Medicine • Reproductive Endocrinology • Urgent Care Medicine

Other Health Care Professionals: (This list is <u>not</u> all inclusive.)

Practitioner Specialty	Value	Other Services Included
Acupuncturist	040	
Alcohol/Drug Detox Services	041	
Ambulance Services	042	
Audiologist/Speech Pathologist	043	
Chiropractor	044	
Freestanding Clinic (Not a Government Agency)	045	
Day Care Facility	046	Medical Mental Health
Dietitian/Licensed Nutritionist	047	
Home Health Provider	048	Home Infusion Therapy
Mental Health	102	Use this code only where provider-specific identifiers are not available for facilities where mental health services are provided by a psychiatrist, psychologist, or social worker.
Advanced Practice Nurse: Anesthetist	049	Nurse Anesthetist/Certified Registered Nurse Anesthetist (CRNA)
Advanced Practice Nurse: Midwife	050	Nurse Midwife
Advanced Practice Nurse: Nurse Practitioner	051	Nurse Practitioner
Advanced Practice Nurse: Psychotherapist	052	Nurse Psychotherapist
Nurse – Other than Advanced Practice	053	
Occupational Therapist	054	
Optometrist	055	
Podiatrist	056	
Physical Therapist	057	
Psychologist	058	
Clinical Social Worker	059	
Public Health or Welfare Agency	060	Federal, state, and local government
Voluntary Health Agency	061	Planned Parenthood
Other Specialty Not Listed Above	062	Hypnosis
Respiratory Therapist	063	
Physician Assistant	064	

Dental: (This list is not all inclusive.)

COMAR Practitioner Specialty	Value	Other Services Included
General Dentist	070	
Endodontist	071	
Orthodontist	072	
Oral Surgeon	073	
Pedodontist	074	
Periodontist	075	
Prosthodontist	076	

Office Facilities: (This list is not all inclusive.)

COMAR Practitioner Specialty	Value	Other Services Included
Freestanding Pharmacy	080	Includes grocery stores
Mail Order Pharmacy	081	
Independent Laboratory	082	
Independent Medical Supply Company	083	Durable Medical Equipment Prosthetic Devices Vision Products Blood
Optician/Optometrist	084	For lenses & eye glasses
All Other Supplies	085	
Freestanding Medical Facility	090	
Freestanding Surgical Facility	091	
Freestanding Imaging Center	092	
Other Facility	093	Dialysis Center Birthing Center

UNIVERSALLY UNIQUE IDENTIFIER (UUID)

Cross Payer Encryption Algorithm

MHCC shall provide each payer an encryption algorithm, **Universally Unique Identifier (UUID)**, using one-way hashing consistent with the Advanced Encryption Standard (AES) recognized by the National Institute of Standards and Technology. Each payer shall maintain the security and preserve the confidentiality of the UUID encryption algorithms provided by MHCC.

A Universally Unique Identifier (UUID) uniquely identifies information in a decentralized system; using the same algorithm across distributed systems will result in the same unique ID for the same value; information labeled with UUIDs can be combined into a single database without needing to resolve name conflicts.

UUIDs will be 12 character positions in length and constructed from information obtained at birth including: Social Security Number, Date of Birth, Month of Birth, Year of Birth, Sex, First Name.

Each payer shall encrypt new Patient/Enrollee Identifiers **(Patient/Enrollee IdentifierU)** in such a manner that each unique value produces an identical unique encrypted data element.

Each payer shall continue to use their current encrypted identifier **(Patient/Enrollee IdentifierP)** coincident with the new identifier.

Using two identifiers will: 1) provide the means to perform trend analysis by cross referencing the two identifiers, and 2) increase the efficacy of the identifiers in the event encryption of one of the algorithms is compromised.

The full encryption software documentation, source code, and executables are bundled into a ZIP file. That software can be downloaded directly from the Commission's website at http://mhcc.dhmh.maryland.gov/payercompliance/Pages/mcdb-uuid.aspx. The file is password protected. The password will be forwarded to the payer contact in an e-mail.

The Commission is strongly encouraging all carriers to consider the simple implementation of the software for the 2012 MCDB submission. That implementation is simply a standalone program that reads in the precursor variables and outputs those same variables plus the UUID.

Questions regarding the Universally Unique Identifier (UUID) Cross Payer Encryption Algorithm should be directed to Mr. Larry Monroe at MHCC at (410) 764-3390 or via e-mail at larry.monroe@maryland.gov.

MARYLAND HEALTH CARE COMMISSION

APPENDIX D

SPECIAL INSTRUCTIONS for

FINANCIAL DATA ELEMENTS

FORMATTED FOR THE 2012 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

FINANCIAL DATA ELEMENTS – Billing and Reimbursement Information

Each of the financial data elements listed must be recorded by line item.

Professional Services file – a line item is defined as a single line entry on a bill/claim for each health care service rendered. The line item contains information on each procedure performed including modifier (if appropriate), service dates, units (if applicable), and practitioner charges. The line item also includes billed charges, allowed amount, patient deductible, patient coinsurance/co-payment, other patient obligations, and reimbursement amount. The value represented by each financial field **must be rounded to whole dollars** (i.e., no decimals).

- *All Fee-for-Service ("Record Status = 1") debit and credit bills must be reconciled to final bills.*
- *For Capitated/Global Contract Services ("Record Status = 8") billed charge, allowed amount, patient deductible, patient coinsurance/co-payment, other patient obligations and reimbursement amount must be reported when available.*

Institutional Services file – a record is defined as a summary of the services received during a stay or visit at an institution. The billed charges, allowed amount, and amounts paid by the payer and patient should reflect a summary of all services provided on the claim. The value represented by each financial field **must be rounded to whole dollars** (i.e., no decimals).

Pharmacy file – a line item is defined as a single line entry on a prescription service. The line item contains information on each prescription filled, including date filled, drug quantity and supply. This line item also includes billed charge, patient deductible, patient coinsurance/co-payment, other patient obligations, and reimbursement amount for each prescription. The value of the financial field must be represented using **two implied decimal places. Use two zeros if cents are not provided.**

FINANCIAL DATA ELEMENTS	**Professional Services** and **Institutional Services Data**		**Pharmacy Data**	
Billed Charge	*Dollar amount as billed by the practitioner/institution for health care services rendered.*	*Rounded to whole dollars (no decimals)*	*Prescription retail price including ingredient cost, dispensing fee, tax, and administrative expenditures.*	*Formatted using 2 implied decimal points*
Allowed Amount	*Retail Amount for the specified procedure code.*	*Rounded to whole dollars (no decimals)*		
Patient Deductible	*Fixed amount that the patient must pay for covered services before benefits are payable.*	*Rounded to whole dollars (no decimals)*	*Fixed amount that the patient must pay for covered services before benefits are payable.*	*Formatted using 2 implied decimal points*
Patient Coinsurance/ Patient Co-payment	*Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.*	*Rounded to whole dollars (no decimals)*	*Specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible.*	*Formatted using 2 implied decimal points*
Other Patient Obligations	*Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.*	*Rounded to whole dollars (no decimals)*	*Any patient liability other than deductible or coinsurance/co-payment. Includes obligations for out-of-network care (balance billing), non-covered services, or penalties.*	*Formatted using 2 implied decimal points*
Note: Total Patient Liability should equal the sum of Patient Deductible, Patient Coinsurance/Patient Co-payment, and Other Patient Obligations. Please make an effort to provide this financial information.				
Reimbursement Amount	*Amount paid to a practitioner, other health professional, office facility, or institution.*	*Rounded to whole dollars (no decimals)*	*Amount paid to the pharmacy by the payer.*	*Formatted using 2 implied decimal points*

MARYLAND HEALTH CARE COMMISSION

APPENDIX E

FILE LAYOUTS

- PROFESSIONAL SERVICES DATA REPORT
- PHARMACY DATA REPORT
- PROVIDER DIRECTORY REPORT
- INSTITUTIONAL SERVICES DATA REPORT
- MEDICAL ELIGIBILITY DATA REPORT

FORMATTED FOR THE 2012 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

PROFESSIONAL SERVICES DATA REPORT SUBMISSION – File Layout

This report details all fee-for-service and capitated encounters provided by health care practitioners and office facilities from **January 1, 2012 through December 31, 2012**. Please provide information on all health care services provided to Maryland residents whether those services were provided by a practitioner or office facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

Payers are permitted to submit the data in either of the following formats:

Option 1, FIXED FORMAT: (preferred)

Using the fixed format, it is possible that multiple services will be reported for each claim. Count each reported health care service even though documented on a single claim. The number of line items will always equal one (1) because one service is written per row.

FIXED FORMAT

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Patient Identifier**P** (payer encrypted)	12	A		2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A		14	25	
4.	Patient Year and Month of Birth (CCYYMM00)	8	N		26	33	99%/99%/ 100%('00')
5.	Patient Sex	1	N		34	34	99%
6.	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	N		35	35	95%
7.	Patient Zip Code	5	N		36	40	99%
8.	Patient Covered by Other Insurance Indicator	1	N		41	41	95%
9.	Coverage Type	1	A		42	42	99%
10.	**Source Company** (renamed from Delivery System Type)	1	N		43	43	99%
11.	Claim Related Condition	1	N		44	44	
12.	Practitioner Federal Tax ID	9	A		45	53	100%
13.	Participating Provider Flag	1	N		54	54	95%
14.	Record Status (renamed from Type of Bill.) (This field must be mapped – see pg. 19)	1	A		55	55	95%
15.	Claim Control Number (Include on each record as this is the key to summarizing service detail to claim level)	23	A		56	78	
16.	Claim Paid Date (CCYYMMDD)	8	N		79	86	95%
17.	Number of Diagnosis Codes	2	N		87	88	
18.	Number of Line Items (always **= 01** for fixed format – see pg. 66)	2	N		89	90	
19.	Diagnosis Code 1 – **Remove imbedded decimal points**	5	A		91	95	99%
20.	Diagnosis Code 2	5	A		96	100	
21.	Diagnosis Code 3	5	A		101	105	
22.	Diagnosis Code 4	5	A		106	110	
23.	Diagnosis Code 5	5	A		111	115	
24.	Diagnosis Code 6	5	A		116	120	
25.	Diagnosis Code 7	5	A		121	125	
26.	Diagnosis Code 8	5	A		126	130	
27.	Diagnosis Code 9	5	A		131	135	
28.	Diagnosis Code 10	5	A		136	140	

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
29.	Service From Date (CCYYMMDD)	8	N		141	148	100%
30.	Service Thru Date* (CCYYMMDD)	8	N		149	156	100%*
31.	Place of Service	2	N		157	158	99%
32.	Service Location Zip Code	5	A		159	163	95%
33.	Service Unit Indicator	1	N		164	164	95%
34.	Units of Service	3	N	1 implied**	165	167	95%
35.	Procedure Code	6	A		168	173	95%
36.	Modifier I (This field must be mapped – see pg. 68)	2	A		174	175	
37.	Modifier II (specific to Modifier I)	2	A		176	177	
38.	Servicing Practitioner ID	11	A		178	188	100%
39.	Billed Charge (line item amounts required – see pg. 48)	9	N		189	197	
40.	Allowed Amount (line item amounts required – see pg. 48)	9	N		198	206	
41.	Reimbursement Amount (line item amounts required – see pg. 48)	9	N		207	215	
42.	Date of Enrollment	8	N		216	223	99%
43.	Date of Disenrollment	8	N		224	231	99%
44.	Patient Deductible (line item amounts required – see pg. 48)	9	N		232	240	
45.	Patient Coinsurance or Patient Co-payment (line item amounts required– see pg. 48)	9	N		241	249	
46.	Other Patient Obligations (line item amounts required– see pg. 48)	9	N		250	258	
47.	Plan Liability	1	N		259	259	95%
48.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A		260	269	95%
49.	Practitioner National Provider Identifier (NPI) number used for Billing	10	A		270	279	95%
50.	Product Type	1	N		280	280	95%
51.	Payer ID Number *(see Appendix A)*	4	A		281	284	100%
52.	Source System	1	A		285	285	

** If the Service Thru Date is not reported, then assume that the Service From Date (data element #29) and the Service Thru Date are the same. ** Implied decimal should only be used for anesthesia time units; all other units should be submitted as integers.*

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

The Professional Services data must link to the Pharmacy, Institutional Services, and Medical Eligibility data by Encrypted Patient Identifier. Encryption of Patient ID must be consistent with encryption of Patient ID in the Pharmacy, Institutional Services, and Medical Eligibility files. MHCC will return files that do not link.

PROFESSIONAL SERVICES DATA REPORT SUBMISSION – File Layout (cont.)

Option 2, VARIABLE FORMAT:

Count each reported service as a health care claim even though the claim may contain multiple services. For example, if a claim documents three (3) services then three (3) occurrences in the line item section must be reported.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

VARIABLE FORMAT

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End	Threshold
1.	Record Identifier	1	N			1	1	100%
2.	Patient Identifier**P** (payer encrypted)	12	A			2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A			14	25	
4.	Patient Year and Month of Birth (CCYYMM00)	8	N			26	33	99%/99%/ 100%('00')
5.	Patient Sex	1	N			34	34	99%
6.	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	N			35	35	95%
7.	Patient Zip Code	5	N			36	40	99%
8.	Patient Covered by Other Insurance Indicator	1	N			41	41	95%
9.	Coverage Type	1	A			42	42	99%
10.	**Source Company** (renamed from Delivery System Type)	1	N			43	43	99%
11.	Claim Related Condition	1	N			44	44	
12.	Practitioner Federal Tax ID	9	A			45	53	100%
13.	Participating Provider Flag	1	N			54	54	95%
14.	Record Status (renamed from Type of Bill) (This field must be mapped – see pg. 19)	1	A			55	55	95%
15.	Claim Control Number (This is the key to summarizing service detail to claim level & must be included on each record.)	23	A			56	78	
16.	Claim Paid Date (CCYYMMDD)	8	N			79	86	95%
17.	Date of Enrollment	8	N			87	94	99%
18.	Date of Disenrollment	8	N			95	102	99%
19.	Number of Line Items (see pg. 66 for clarification)	2	N			103	104	
▸	**Items 20-40 represent line items only. Repeat format 20-40 for each additional line item.**	130			26	105		
20.	Number of Diagnosis Codes	2	N					
21.	Diagnosis Field will hold up to 10 diagnosis codes. (Leave fields blank if not available.) **Remove imbedded decimal points**	5	A		10			99%
22.	Service From Date (CCYYMMDD)	8	N					100%
23.	Service Thru Date* (CCYYMMDD)	8	N					100%*
24.	Place of Service	2	N					99%

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Occurs	Start	End	Threshold
25.	Service Location Zip Code	5	A					95%
26.	Service Unit Indicator	1	N					95%
27.	Units of Service	3	N	1 implied**				95%
28.	Procedure Code	6	A					95%
29.	Modifier I (This field must be mapped – see pg. 68)	2	A					
30.	Modifier II (specific to Modifier I)	2	A					
31.	Servicing Practitioner ID	11	A					100%
32.	Billed Charge (line item amounts required – see pg. 48)	9	N					
33.	Allowed Amount (line item amounts required – see pg. 48)	9	N					
34.	Reimbursement Amount (line item amounts required – see pg. 48)	9	N					
35.	Patient Deductible (line item amounts required – see pg. 48)	9	N					
36.	Patient Coinsurance or Co-payment (line item amounts required – see pg. 48)	9	N					
37.	Other Patient Obligations (line item amounts required– see pg. 48)	9	N					
38.	Plan Liability	1	N					95%
39.	Servicing Practitioner Individual National Provider Identifier (NPI) number	10	A					95%
40.	Practitioner National Provider Identifier (NPI) number used for Billing	10	A					95%
41.	Product Type	1	N					95%
42.	Payer ID Number *(see Appendix A)*	4	A					100%
43.	Source System	1	A					

** If the Service Thru Date is not reported, then assume that the Service From Date (data element #22) and the Service Thru Date are the same.*

*** Implied decimal should only be used for anesthesia time units; all other units should be submitted as integers.*

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

The Professional Services data must link to the Pharmacy, Institutional Services, and Medical Eligibility data by Encrypted Patient Identifier. Encryption of Patient ID must be consistent with encryption of Patient ID in the Pharmacy, Institutional Services, and Medical Eligibility files. MHCC will return files that do not link.

PHARMACY DATA REPORT SUBMISSION – File Layout

This report details all prescription drug encounters for your enrollees **filled from January 1, 2012 through December 31, 2012.** Please provide information on all pharmacy services provided to Maryland residents whether the services were provided by a pharmacy located in-State or out-of-State. **Do not include pharmacy supplies or prosthetics.**

COMAR 10.25.06 specifies the Pharmacy Data Report be submitted separately from the Professional Services Data Report.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

File Layout for the Pharmacy Data Report is a 192 byte **fixed format.** The file layout is as follows:

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Patient Identifier**P** (payer encrypted)	12	A		2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A		14	25	
4.	Patient Sex	1	N		26	26	99%
5.	Patient Zip Code	5	N		27	31	99%
6.	Patient Year and Month of Birth (CCYYMM00)	8	N		32	39	99%/99%/ 100%('00')
7.	Pharmacy NCPDP Number **(left justified)**	7	N		40	46	100%
8.	Pharmacy Zip Code (location where prescription was filled and dispensed)	5	N		47	51	95%
9.	Practitioner DEA # (left justified; for many payers the last 2 positions on the right will be blank)*	11	A		52	62	99%
10.	Fill Number	2	N		63	64	
11.	NDC Number	11	N		65	75	100%
12.	Drug Compound	1	N		76	76	
13.	Drug Quantity	5	N		77	81	99%
14.	Drug Supply	3	N		82	84	99%
15.	Date Filled (CCYYMMDD)	8	N		85	92	100%/95%/ 95%
16.	Date Prescription Written (CCYYMMDD)	8	N		93	100	
17.	Billed Charge (line item amounts required – see pg. 48)	9	N	2	101	109	
18.	Reimbursement Amount (line item amounts required – see pg. 48)	9	N	2	110	118	
19.	Prescription Claim Number	15	N		119	133	
20.	Prescribing Practitioner Individual National Provider Identifier (NPI)#	10	A		134	143	95%
21.	Patient Deductible (line item amounts required – see pg. 48)	9	N	2	144	152	
22.	Patient Coinsurance or Patient Co-payment (line item amounts – see pg. 48)	9	N	2	153	161	

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
23.	Other Patient Obligations (line item amounts required – see pg. 48)	9	N	2	162	170	
24.	Date of Enrollment	8	N		171	178	95%
25.	Date of Disenrollment	8	N		179	186	95%
26.	Source of Processing	1	A		187	187	100%
27.	Payer ID Number *(see Appendix A)*	4	A		188	191	100%
28.	Source System	1	A		192	192	

** Please note which of the following you are using to link the Pharmacy Data Report with the Provider Directory Report:*

☐ DEA (Drug Enforcement Agency) # ☐ Other (exception waiver from MHCC required)

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

The Pharmacy data must link to Professional Services, Institutional Services, and Medical Eligibility data by Encrypted Patient Identifier. Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services, Institutional Services, and Medical Eligibility files. MHCC will return files that do not link.

PROVIDER DIRECTORY REPORT SUBMISSION – File Layout

This report details all health care Practitioners *(including other health care professionals, dental/vision services covered under a health benefit plan, and office facilities)* and Suppliers that provided services to your enrollees from **January 1, 2012 through December 31, 2012**. Please provide information for all in-State Maryland practitioners/suppliers and all out-of-State practitioners/suppliers serving Maryland residents.

File Layout for the Provider Directory Report is a 127 byte **fixed format.** The file layout is as follows:

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Practitioner/Supplier ID (payer encrypted)	11	A		2	12	100%
3.	Practitioner/Supplier Federal Tax ID (without embedded dashes)	9	A		13	21	100%
4.	Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization (Truncate if over 31 characters)	31	A		22	52	99%
5.	Practitioner/Supplier First Name	19	A		53	71	99%
6.	Practitioner Middle Initial	1	A		72	72	
7.	Practitioner Name Suffix	4	A		73	76	
8.	Practitioner Credential	5	A		77	81	
9.	Practitioner/Supplier Specialty – 1	3	A		82	84	100%
10.	Practitioner/Supplier Specialty – 2	3	A		85	87	
11.	Practitioner/Supplier Specialty – 3	3	A		88	90	
12.	Practitioner DEA #	11	A		91	101	99%
13.	Indicator for Multi-Practitioner Health Care Organization	1	A		102	102	99%
14.	Practitioner Individual National Provider Identifier (NPI) number	10	A		103	112	
15.	Practitioner Organizational National Provider Identifier (NPI) number	10	A		113	122	
16.	Payer ID Number *(see Appendix A)*	4	A		123	126	100%
17.	Source System	1	A		127	127	

REMINDERS !!!

- Use specific (separate) fields for practitioner First Name and Last Name.
- Confirm **Practitioner/Supplier ID #** matches **Servicing Practitioner ID #** in the Professional Services File Layout.
- Confirm **Practitioner DEA #** matches **Practitioner DEA #** in the Pharmacy File Layout.
- If the practice is a Multi-Practitioner Health Care Organization, then **Practitioner Organizational NPI #** (data element #15) should be filled.

INSTITUTIONAL SERVICES DATA REPORT SUBMISSION – File Layout

This report details all institutional health care services *(including hospital inpatient, outpatient, and emergency department services)* provided to your enrollees from **January 1, 2012 through December 31, 2012**. Please provide information on all institutional services provided to Maryland residents whether by a health care facility located in-State or out-of-State.

*(Reminder: **Patient Liability** is calculated using these three financial fields: **Patient Deductible**, **Patient Coinsurance/Co-payment**, and **Other Patient Obligations**. Total Patient Liability **should equal the sum** of Patient Deductible + Patient Coinsurance/Co-payment + Other Patient Obligations.)*

This summary record should reflect all charges and payments from an interim or final claim. To avoid sending duplicate charges and payments, submit summaries from interim claims only when a final claim does not exist for a visit or stay.

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Patient Identifier**P** (payer encrypted)	12	A		2	13	100%
3.	Patient Identifier**U** (UUID encrypted)	12	A		14	25	
4.	Patient Year and Month of Birth (CCYYMM00)	8	N		26	33	99% /99%/ 100%('00')
5.	Patient Sex	1	N		34	34	99%
6.	Patient Zip Code of Residence	5	N		35	39	99%
7.	Date of Enrollment	8	N		40	47	99%
8.	Date of Disenrollment	8	N		48	55	99%
9.	Hospital/Facility Federal Tax ID	9	A		56	64	100%
10.	Hospital/Facility National Provider Identifier (NPI) Number	10	A		65	74	95%
11.	Hospital/Facility Medicare Provider Number	6	A		75	80	
12.	Hospital/Facility Participating Provider Flag	1	N		81	81	95%
13.	Claim Control Number	23	A		82	104	
14.	Record Type	2	N		105	106	
15.	Type of Admission	1	N		107	107	95%
16.	**Point of Origin for Admission or Visit** (renamed from Source of Admission)	1	N		108	108	95%
17.	Patient Discharge Status	2	N		109	110	
18.	Date of Admission or Start of Service	8	N		111	118	99%
19.	Date of Discharge or End of Service*	8	N		119	126	99%*
20.	Diagnosis Code Indicator	1	N		127	127	
21.	Primary Diagnosis – **Remove embedded decimal points**	5	A		128	132	99%
22.	Primary Diagnosis present on Admission	1	A		133	133	
23.	Other Diagnosis Code 1	5	A		134	138	
24.	Other Diagnosis Code 1 present on Admission 1	1	A		139	139	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
25.	Other Diagnosis Code 2	5	A		140	144	
26.	Other Diagnosis Code 2 present on Admission 2	1	A		145	145	
27.	Other Diagnosis Code 3	5	A		146	150	
28.	Other Diagnosis Code 3 present on Admission 3	1	A		151	151	
29.	Other Diagnosis Code 4	5	A		152	156	
30.	Other Diagnosis Code 4 present on Admission 4	1	A		157	157	
31.	Other Diagnosis Code 5	5	A		158	162	
32.	Other Diagnosis Code 5 present on Admission 5	1	A		163	163	
33.	Other Diagnosis Code 6	5	A		164	168	
34.	Other Diagnosis Code 6 present on Admission 6	1	A		169	169	
35.	Other Diagnosis Code 7	5	A		170	174	
36.	Other Diagnosis Code 7 present on Admission 7	1	A		175	175	
37.	Other Diagnosis Code 8	5	A		176	180	
38.	Other Diagnosis Code 8 present on Admission 8	1	A		181	181	
39.	Other Diagnosis Code 9	5	A		182	186	
40.	Other Diagnosis Code 9 present on Admission 9	1	A		187	187	
41.	Other Diagnosis Code 10	5	A		188	192	
42.	Other Diagnosis Code 10 present on Admission 10	1	A		193	193	
43.	Other Diagnosis Code 11	5	A		194	198	
44.	Other Diagnosis Code 11 present on Admission 11	1	A		199	199	
45.	Other Diagnosis Code 12	5	A		200	204	
46.	Other Diagnosis Code 12 present on Admission 12	1	A		205	205	
47.	Other Diagnosis Code 13	5	A		206	210	
48.	Other Diagnosis Code 13 present on Admission 13	1	A		211	211	
49.	Other Diagnosis Code 14	5	A		212	216	
50.	Other Diagnosis Code 14 present on Admission 14	1	A		217	217	
51.	Other Diagnosis Code 15	5	A		218	222	
52.	Other Diagnosis Code 15 present on Admission 15	1	A		223	223	
53.	Other Diagnosis Code 16	5	A		224	228	
54.	Other Diagnosis Code 16 present on Admission 16	1	A		229	229	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
55.	Other Diagnosis Code 17	5	A		230	234	
56.	Other Diagnosis Code 17 present on Admission 17	1	A		235	235	
57.	Other Diagnosis Code 18	5	A		236	240	
58.	Other Diagnosis Code 18 present on Admission 18	1	A		241	241	
59.	Other Diagnosis Code 19	5	A		242	246	
60.	Other Diagnosis Code 19 present on Admission 19	1	A		247	247	
61.	Other Diagnosis Code 20	5	A		248	252	
62.	Other Diagnosis Code 20 present on Admission 20	1	A		253	253	
63.	Other Diagnosis Code 21	5	A		254	258	
64.	Other Diagnosis Code 21 present on Admission 21	1	A		259	259	
65.	Other Diagnosis Code 22	5	A		260	264	
66.	Other Diagnosis Code 22 present on Admission 22	1	A		265	265	
67.	Other Diagnosis Code 23	5	A		266	270	
68.	Other Diagnosis Code 23 present on Admission 23	1	A		271	271	
69.	Other Diagnosis Code 24	5	A		272	276	
70.	Other Diagnosis Code 24 present on Admission 24	1	A		277	277	
71.	Other Diagnosis Code 25	5	A		278	282	
72.	Other Diagnosis Code 25 present on Admission 25	1	A		283	283	
73.	Other Diagnosis Code 26	5	A		284	288	
74.	Other Diagnosis Code 26 present on Admission 26	1	A		289	289	
75.	Other Diagnosis Code 27	5	A		290	294	
76.	Other Diagnosis Code 27 present on Admission 27	1	A		295	295	
77.	Other Diagnosis Code 28	5	A		296	300	
78.	Other Diagnosis Code 28 present on Admission 28	1	A		301	301	
79.	Other Diagnosis Code 29	5	A		302	306	
80.	Other Diagnosis Code 29 present on Admission 29	1	A		307	307	
81.	Attending Practitioner Individual National Provider Identifier (NPI) number	10	A		308	317	95%
82.	Operating Practitioner Individual National Provider Identifier (NPI) number	10	A		318	327	
83.	Procedure Code Indicator	1	N		328	328	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
84.	Principal Procedure Code 1	6	A		329	334	
85.	Procedure Code 1 Modifier I	2	A		335	336	
86.	Procedure Code 1 Modifier II	2	A		337	338	
87.	Other Procedure Code 2	6	A		339	344	
88.	Procedure Code 2 Modifier I	2	A		345	346	
89.	Procedure Code 2 Modifier II	2	A		347	348	
90.	Other Procedure Code 3	6	A		349	354	
91.	Procedure Code 3 Modifier I	2	A		355	356	
92.	Procedure Code 3 Modifier II	2	A		357	358	
93.	Other Procedure Code 4	6	A		359	364	
94.	Procedure Code 4 Modifier I	2	A		365	366	
95.	Procedure Code 4 Modifier II	2	A		367	368	
96.	Other Procedure Code 5	6	A		369	374	
97.	Procedure Code 5 Modifier I	2	A		375	376	
98.	Procedure Code 5 Modifier II	2	A		377	378	
99.	Other Procedure Code 6	6	A		379	384	
100.	Procedure Code 6 Modifier I	2	A		385	386	
101.	Procedure Code 6 Modifier II	2	A		387	388	
102.	Other Procedure Code 7	6	A		389	394	
103.	Procedure Code 7 Modifier I	2	A		395	396	
104.	Procedure Code 7 Modifier II	2	A		397	398	
105.	Other Procedure Code 8	6	A		399	404	
106.	Procedure Code 8 Modifier I	2	A		405	406	
107.	Procedure Code 8 Modifier II	2	A		407	408	
108.	Other Procedure Code 9	6	A		409	414	
109.	Procedure Code 9 Modifier I	2	A		415	416	
110.	Procedure Code 9 Modifier II	2	A		417	418	
111.	Other Procedure Code 10	6	A		419	424	
112.	Procedure Code 10 Modifier I	2	A		425	426	
113.	Procedure Code 10 Modifier II	2	A		427	428	
114.	Other Procedure Code 11	6	A		429	434	
115.	Procedure Code 11 Modifier I	2	A		435	436	
116.	Procedure Code 11 Modifier II	2	A		437	438	
117.	Other Procedure Code 12	6	A		439	444	
118.	Procedure Code 12 Modifier I	2	A		445	446	
119.	Procedure Code 12 Modifier II	2	A		447	448	
120.	Other Procedure Code 13	6	A		449	454	
121.	Procedure Code 13 Modifier I	2	A		455	456	
122.	Procedure Code 13 Modifier II	2	A		457	458	
123.	Other Procedure Code 14	6	A		459	464	
124.	Procedure Code 14 Modifier I	2	A		465	466	
125.	Procedure Code 14 Modifier II	2	A		467	468	

	Field Name	Length	Type A= alphanumeric N=numeric	Dec	Start	End	Threshold
126.	Other Procedure Code 15	6	A		469	474	
127.	Procedure Code 15 Modifier I	2	A		475	476	
128.	Procedure Code 15 Modifier II	2	A		477	478	
129.	Diagnosis Related Groups (DRGs) Number	3	A		479	481	
130.	DRG Grouper Name	1	N		482	482	
131.	DRG Grouper Version	2	N		483	484	
132.	Billed Charge	9	N		485	493	
133.	Allowed Amount	9	N		494	502	
134.	Reimbursement Amount	9	N		503	511	
135.	Total Patient Deductible	9	N		512	520	
136.	Total Patient Coinsurance or Patient Co-payment	9	N		521	529	
137.	Total Other Patient Obligations	9	N		530	538	
138.	Coordination of Benefit Savings or Other Payer Payments	9	N		539	547	
139.	Type of Bill	3	A		548	550	99%
140.	Patient Covered by Other Insurance Indicator	1	N		551	551	
141.	Payer ID Number *(see Appendix A)*	4	A		552	555	100%
142.	Source System	1	A		556	556	

** If the Date of Discharge or End of Service (data element #19) is not reported, then assume that the Date of Admission or Start of Service (data element #18) and the Date of Discharge or End of Service are the same.*

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

The Institutional Services data must link to Professional Services, Pharmacy, and Medical Eligibility data by Encrypted Patient Identifier.

Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services, Pharmacy, and Medical Eligibility files.

MHCC will return files that do not link.

MEDICAL ELIGIBILITY DATA REPORT – File Layout

This report details information on the characteristics of all enrollees covered for medical services under the plan from **January 1, 2012 through December 31, 2012**. Please provide an entry for each month that the enrollee was covered by a health benefit plan regardless of whether or not the enrollee received any covered services during the reporting year.

(For example, an enrollee with 12 months of coverage will have 12 eligibility records; an enrollee with 6 months of coverage will only have 6 records.)

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
1.	Record Identifier	1	N		1	1	100%
2.	Encrypted Enrollee's Identifier**P** (payer encrypted)	12	A		2	13	100%
3.	Encrypted Enrollee's Identifier**U** (UUID encrypted)	12	A		14	25	100%*
4.	Enrollee Year and Month of Birth (CCYYMM00)	8	N		26	33	99% / 95% / 100%('00')
5.	Enrollee Sex	1	N		34	34	99%
6.	Enrollee Zip Code of Residence	5	N		35	39	99%
7.	Enrollee County of Residence	3	N		40	42	95%
8.	Source of Enrollee Race/Ethnicity Information	1	N		43	43	95%
9.	Enrollee OMB Race 1	1	N		44	44	
10.	Enrollee OMB Race 2	1	N		45	45	
11.	Enrollee OMB Race 3 *(for future use)*	1	N		46	46	
12.	Enrollee OMB Hispanic Ethnicity 1	1	N		47	47	
13.	Enrollee Other Ethnicity 2 *(for future use)*	1	N		48	48	
14.	Enrollee Preferred Spoken Language *(for future use)*	2	N		49	50	
15.	Coverage Type	1	A		51	51	99%
16.	**Source Company** (renamed from Delivery System Type)	1	A		52	52	99%
17.	Product Type	1	N		53	53	95%
18.	Policy Type	1	N		54	54	95%
19.	Encrypted Contract or Group Number (payer encrypted)	20	A		55	74	95%
20.	Employer Federal Tax ID Number	9	A		75	83	95%
21.	Medical Services Indicator	1	N		84	84	95%
22.	Pharmacy Services Indicator	1	N		85	85	95%
23.	Behavioral Health Services Indicator	1	N		86	86	95%
24.	Dental Services Indicator	1	N		87	87	95%

	Field Name	Length	Type A=alphanumeric N=numeric	Dec	Start	End	Threshold
25.	Plan Liability	1	N		88	88	95%
26.	Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	1	N		89	89	95%
27.	Start Date of Coverage (in the month CCYYMMDD)	8	N		90	97	95%
28.	End Date of Coverage (in the month CCYYMMDD)	8	N		98	105	95%
29.	Date of FIRST Enrollment **	8	N		106	113	99%
30.	Date of Disenrollment	8	N		114	121	99%
31.	Relationship to Policyholder	1	N		122	122	95%
32.	Payer ID Number *(see Appendix A)*	4	A		123	126	100%
33.	Source System	1	A		127	127	

** Note: The Commission expects the algorithm to be applied to every eligibility record.*

*** Unlike the Date of Enrollment listed on the other files, which refers to the start date of enrollment in this data submission period, this* ***Date of FIRST Enrollment*** *should reflect the date that the patient was initially enrolled with your organization.*

DATA WITHOUT PROPER DOCUMENTATION WILL BE RETURNED!

The Medical Eligibility data must link to Professional Services, Pharmacy, and Institutional Services data by Encrypted Patient Identifier.

Encryption of Patient ID must be consistent with encryption of Patient ID in Professional Services, Pharmacy, and Institutional Services files.

MHCC will return files that do not link.

MARYLAND HEALTH CARE COMMISSION

APPENDIX F

DATA DICTIONARY

- PROFESSIONAL SERVICES DATA REPORT
- PHARMACY DATA REPORT
- PROVIDER DIRECTORY REPORT
- INSTITUTIONAL SERVICES DATA REPORT
- MEDICAL ELIGIBILITY DATA REPORT

FORMATTED FOR THE 2012 MARYLAND MEDICAL CARE DATA BASE (MCDB) SUBMISSION

Data Dictionary – PROFESSIONAL SERVICES

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.06 D.(1)	The value is 1	**1 Professional Services**
Patient Identifier**P** (payer encrypted)	10.25.06.06 D.(2)	Patient's unique identification number assigned by payer and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Pharmacy Claims and Institutional Services)
Patient Identifier**U** (UUID encrypted)	10.25.06.06 D.(2)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 46. A full description is available in the UUID Users' Manual.
Patient Year and Month of Birth	10.25.06.06 D.(3)	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	10.25.06.06 D.(4)	Sex of the patient.	1 Male 2 Female 3 Unknown
Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	10.25.06.06 D.(5)	Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA)	0 No 1 Yes
Patient Zip Code	10.25.06.06 D.(6)	Zip code of patient's residence.	5-digit US Postal Service code
Patient Covered by Other Insurance Indicator	10.25.06.06 D.(7)	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown
Coverage Type	10.25.06.06 D.(8)	Patient's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Comprehensive Standard Health Benefit Plan [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees] 9 Health Insurance Partnership (HIP) A Student Health Plan Z Unknown

Field Name	COMAR	Description	Field Contents
Source Company *(renamed from Delivery System Type)*	10.25.06.06 D.(9)	Defines the payer company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit
Claim Related Condition	10.25.06.06 D.(10)	Describes connection, if any, between patient's condition and employment, automobile accident, or other accident.	0 Non-accident (default) 1 Work 2 Auto Accident 3 Other Accident 9 Unknown
Practitioner Federal Tax ID	10.25.06.06 D.(11)	Employer Tax ID of the practitioner, practice or office facility receiving payment for services.	
Participating Provider Flag	10.25.06.06 D.(12)	Indicates if the service was provided by a provider that participates in the payer's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded
Record Status *(renamed from Type of Bill)*	10.25.06.06 D.(13)	Describes payment and adjustment status of a claim. Adjustments include paying a claim more than once, paying additional services that may have been denied, or crediting a provider due to overpayment or paying the wrong provider.	1 Final Bill 8 Capitated or Global Contract Services
Claim Control Number	10.25.06.06 D.(14)	Internal payer claim number used for tracking.	
Claim Paid Date	10.25.06.06 D.(15)	The date a claim was authorized for payment.	CCYYMMDD
Number of Diagnosis Codes	10.25.06.06.D.(16)	The number of diagnosis codes, up to ten.	1 through 10. Maximum is 10.
Number of Line Items	10.25.06.06.D.(17)	If using **Variable Format**, the # of line items completed in the variable portion (data elements 20-40) must match the value entered for this data element, maximum value for this data and # of line items is 26. If using **Fixed Format**, the number of line items is always equal to one (1) because only one service is written per row.	

Field Name	COMAR	Description	Field Contents
Diagnosis Codes	10.25.06.06.D.(18)-D.(27)	The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 9 codes), if applicable at time of service. **Remove embedded decimal point.**	
Service From Date	10.25.06.06.D.(28)	First date of service for a procedure in this line item.	CCYYMMDD
Service Thru Date	10.25.06.06.D.(29)	Last date of service for this line item.	CCYYMMDD
Place of Service	10.25.06.06.D.(30)	Two-digit numeric code that describes where a service was rendered.	**CMS: (definitions listed on pages 28 - 29)** 11 Provider's Office 12 Patient's Home 13 Assisted Living Facility **17 Walk-in Retail Health Clinic** New! 20 Urgent Care Facility 21 Inpatient Hospital 22 Outpatient Hospital 23 Emergency Room – Hospital 24 Ambulatory Surgical Center 25 Birthing Center 26 Military Treatment Facility 31 Skilled Nursing Facility 32 Nursing Facility 33 Custodial Care Facility 34 Hospice 41 Ambulance – Land 42 Ambulance – Air or Water 51 Inpatient Psychiatric Facility 52 Psychiatric Facility – Partial Hospitalization 53 Community Mental Health Center 54 Intermediate Care Facility/Mentally Retarded 55 Residential Substance Abuse Treatment Facility 56 Psychiatric Residential Treatment Center 57 Non-residential Substance Abuse Treatment Facility 60 Mass Immunization Center 61 Comprehensive Inpatient Rehabilitation Facility 62 Comprehensive Outpatient Rehabilitation Facility 65 End-Stage Renal Disease Treatment Facility 71 State or Local Public Health Clinic 72 Rural Health Clinic 81 Independent Laboratory & Imaging 99 Other Place of Service
Service Location Zip Code	10.25.06.06.D.(31)	Zip code for location where service described was provided.	5-digit US Postal Service code

Field Name	COMAR	Description	Field Contents
Service Unit Indicator	10.25.06.06.D.(32)	Category of service as it corresponds to Units data element.	0 Values reported as zero (no allowed services) 1 Transportation (ambulance air or ground) Miles 2 Anesthesia Time Units 3 Services 4 Oxygen Units 5 Units of Blood 6 Allergy Tests 7 Lab Tests 8 Minutes of Anesthesia (waiver required)
Units of Service	10.25.06.06.D.(33)	Quantity of services or number of units for a service or minutes of anesthesia.	One (1) implied decimal for anesthesia time units; all other units submit as integers.
Procedure Code	10.25.06.06.D.(34)	Describes the health care service provided (i.e., CPT-4, HCPCS, ICD-9-CM, ICD-10-CM).	
Modifier I	10.25.06.06.D.(35)	Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field.	MHCC accepts national standard modifiers approved by the American Medical Association as published in the 2008 Current Procedure Terminology. Modifiers approved for Hospital Outpatient use: Level I (CPT) and Level II (HCPCS/National) modifiers. Nurse Anesthetist services are to be reported using the following Level II (HCPCS) modifiers: • **QX** – Nurse Anesthetist service; under supervision of a doctor • **QZ** – Nurse Anesthetist service; w/o the supervision of a doctor
Modifier II	10.25.06.06.D.(36)	Specific to Modifier I.	
Servicing Practitioner ID	10.25.06.06.D.(37)	Payer-specific identifier for the practitioner rendering health care service(s).	
Billed Charge	10.25.06.06.D.(38)	A practitioner's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	
Allowed Amount	10.25.06.06.D.(39)	Total patient and payer liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	10.25.06.06.D.(40)	Amount paid to Employer Tax ID # of rendering physician as listed on claim. **DO NOT USE DECIMALS**	

Field Name	COMAR	Description	Field Contents
Date of Enrollment	10.25.06.06.D.(41)	The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 66)	CCYYMMDD Date is 20120101 if patient is enrolled at start of 2012. Enter other date if patient **not enrolled** at start of year, enrolled during 2012.
Date of Disenrollment	10.25.06.06.D.(42)	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 66)	CCYYMMDD **Leave blank** if patient is still enrolled on 20121231. If patient disenrolled before end of year enter date disenrolled.
Patient Deductible	10.25.06.06.D.(43)	The fixed amount that the patient must pay for covered medical services before benefits are payable. **DO NOT USE DECIMALS**	
Patient Coinsurance or Patient Co-payment	10.25.06.06.D.(44)	The specified amount or percentage the patient is required to contribute towards covered medical services after any applicable deductible. **DO NOT USE DECIMALS**	
Other Patient Obligations	10.25.06.06.D.(45)	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payer reimbursement), non-covered services, or penalties. **DO NOT USE DECIMALS**	
*Note: Total Patient Liability **should equal the sum** of Patient Deductible (43), Patient Coinsurance/Co-payment (44), and Other Patient Obligations (45).*			
Plan Liability	10.25.06.06.D.(46)	Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as Administrative Services Only (ASO)	1 Risk (under Maryland contract) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured)
Servicing Practitioner Individual National Provider Identifier (NPI) number	10.25.06.06.D.(47)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Practitioner National Provider Identifier (NPI) number used for Billing.	10.25.06.06.D.(48)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner or an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf

Field Name	COMAR	Description	Field Contents
Product Type		Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). (Please code based on how the product is primarily marketed, and most importantly be consistent from year to year. If not sure, send an e-mail describing the product to Larry Monroe at larry.monroe@maryland.gov)	1 Exclusive Provider Organization (in any form) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic
Payer ID Number		Payer assigned submission identification number (see Appendix A on page 38).	
Source System		Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 14, please be sure to list the source system that corresponds with the letter assigned.) For payers with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.

Data Dictionary – PHARMACY SERVICES

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.07.C.(1)	The value is 2	**2 Pharmacy Services**
Patient Identifier**P** (payer encrypted)	10.25.06.07.C.(2)	Patient's unique identification number assigned by payer and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Professional Services and Institutional Services)
Patient Identifier**U** (UUID encrypted)	10.25.06.07.C.(2)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 46. A full description is available in the UUID Users' Manual.
Patient Sex	10.25.06.07.C.(3)	Sex of Patient.	1 Male 2 Female 3 Unknown
Patient Zip Code	10.25.06.07.C.(4)	Zip code of patient's residence.	5-digit US Postal Service code
Patient Year and Month of Birth	10.25.06.07.C.(5)	Date of patient's birth using 00 instead of day.	CCYYMM00
Pharmacy NCPDP Number	10.25.06.07.C.(6)	Unique 7 digit number assigned by the National Council for Prescription Drug Program (NCPDP).	
Pharmacy Zip Code	10.25.06.07.C.(7)	Zip code of pharmacy where prescription was filled and dispensed.	5-digit US Postal Service code
Practitioner DEA #	10.25.06.07.C.(8)	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA # in Provider File.
Fill Number	10.25.06.07.C.(9)	The code used to indicate if the prescription is an original prescription or a refill. Use '01' for all refills if the specific number of the prescription refill is not available.	00 New prescription/Original 01 – 99 Refill number
NDC Number	10.25.06.07.C.(10)	National Drug Code 11 digit number.	
Drug Compound	10.25.06.07.C.(11)	Indicates a mix of drugs to form a compound medication.	1 Non-compound 2 Compound
Drug Quantity	10.25.06.07.C.(12)	Number of units of medication dispensed.	
Drug Supply	10.25.06.07.C.(13)	Estimated number of days of dispensed supply.	

Field Name	COMAR	Description	Field Contents
Date Filled	10.25.06.07.C.(14)	Date prescription was filled.	CCYYMMDD
Date Prescription Written	10.25.06.07.C.(15)	Date prescription was written.	CCYYMMDD
Billed Charge	10.25.06.07.C.(16)	Retail amount for drug including dispensing fees and administrative costs. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Reimbursement Amount	10.25.06.07.C.(17)	Amount paid to the pharmacy by payer. Do not include patient copayment or sales tax. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Prescription Claim Number	10.25.06.07.C.(18)	Internal payer claim number used for tracking.	A credit should have the same claim number as the original debit record.
Prescribing Practitioner Individual National Provider Identifier (NPI) number	10.25.06.07.C.(19)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Patient Deductible	10.25.06.07.C.(20)	The fixed amount that the patient must pay for covered pharmacy services before benefits are payable. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Patient Coinsurance/ Patient Co-payment	10.25.06.07.C.(21)	The specified amount or percentage the patient is required to contribute towards covered pharmacy services after any applicable deductible. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	
Other Patient Obligations	10.25.06.07.C.(22)	Any patient obligations other than the deductible or coinsurance/co-payment. This could include obligations for non-formulary drugs, non-covered pharmacy services, or penalties. **MUST INCLUDE 2 IMPLIED DECIMAL PLACES.**	

*Note: Total Patient Liability **should equal the sum** of Patient Deductible (20), Patient Coinsurance/Co-payment (21), and Other Patient Obligations (22).*

Field Name	COMAR	Description	Field Contents
Date of Enrollment	10.25.06.07.C.(23)	The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 66)	CCYYMMDD Date is 20120101 if patient is enrolled at start of 2012. Enter other date if patient **not enrolled** at start of year, enrolled during 2012.
Date of Disenrollment	10.25.06.07.C.(24)	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 66)	CCYYMMDD **Leave blank** if patient is still enrolled on 20121231. If patient disenrolled before end of year enter date disenrolled.
Source of Processing		The source processing the pharmacy claim.	1 Processed Internally by Payer 2 Argus Health Systems, Inc. 3 Caremark, LLC 4 Catalyst Rx, Inc. 5 Envision Pharmaceutical Services, Inc. 6 Express Scripts, Inc. 7 Medco Health, LLC 8 National Employee Benefit Companies, Inc. dba/Ideal Scripts 9 NextRx Services, Inc. A Atlantic Prescription Services, LLC B Benecard Services, Inc. C BioScrip PBM Services, LLC D Futurescripts, LLC E Health E Systems F HealthTran, LLC G Innoviant, Inc. H MaxorPlus I Medical Security Card Company J MedImpact Healthcare Systems, Inc. K MemberHealth, LLC L PharmaCare Management Services, LLC M Prime Therapeutics, LLC N Progressive Medical, Inc. O RxAmerica, LLC P RxSolutions, Inc. Q Scrip World, LLC R Tmesys, Inc. S WellDynerx, Inc. T Other Source Not Listed Z Unknown

Field Name	COMAR	Description	Field Contents
Payer ID Number		Payer assigned submission identification number (see Appendix A on page 38).	
Source System		Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 14, please be sure to list the source system that corresponds with the letter assigned.) For payers with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.

Data Dictionary – PROVIDER DIRECTORY

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.06 D.(1)	The value is 3	**3 Provider Services**
Practitioner/Supplier ID	10.25.06.08.D.(2)	Payer-specific identifier for a practitioner, practice, or office facility rendering health care service(s).	
Practitioner/Supplier Federal Tax ID (without embedded dashes)	10.25.06.08.D.(3)	Employer Tax ID # of the practitioner, practice or office facility receiving payment for services.	Same as Federal Tax ID # in Professional Services File.
Practitioner/Supplier Last Name or Multi-practitioner Health Care Organization	10.25.06.08.D.(4)	Last name of practitioner or complete name of multi-practitioner health care organization.	**Please truncate if name of practitioner or medical organization exceeds 31 characters.**
Practitioner/Supplier First Name	10.25.06.08.D.(5)	Practitioner's first name.	Individual provider's first name.
Practitioner Middle Initial	10.25.06.08.D.(6)		First letter of individual provider's middle name.
Practitioner Name Suffix	10.25.06.08.D.(7)		Individual provider's name suffix, such as Jr., Sr., II, III, IV, or V.
Practitioner Credential	10.25.06.08.D.(8)		Abbreviations for professional degrees or credentials used or held by an individual provider, such as MD, DDS, CSW, CNA, AA, NP, PSY.
Practitioner/Supplier Specialty – 1	10.25.06.08.D.(9)	The health care field in which a physician, licensed health care professional, dental practitioner, or office facility has been certified. Up to 3 codes may be listed.	**<u>Physicians:</u>** 001 General Practice 002 General Surgery 003 Allergy & Immunology 004 Anesthesiology 005 Cardiology 006 Dermatology 007 Emergency Medicine 008 Endocrinology Medicine 009 Family Practice 010 Gastroenterology 011 Geriatrics 012 Hand Surgery
Practitioner/Supplier Specialty – 2	10.25.06.08.D.(10)		
Practitioner/Supplier Specialty – 3	10.25.06.08.D.(11)		

Field Name	COMAR	Description	Field Contents
Practitioner/Supplier Specialty (con't.)			013 Hematology 014 Internal Medicine 015 Infectious Disease 101 Multi-Specialty Medical Practice 016 Nephrology 100 Neonatology 017 Neurology 018 Nuclear Medicine 039 Obstetrics/Gynecology 019 Oncology 020 Ophthalmology 021 Orthopedic Surgery 022 Osteopathy (includes manipulations) 023 Otology, Laryngology, Rhinology, Otolaryngology 024 Pathology 025 Pediatrics 026 Peripheral Vascular Disease or Surgery 027 Plastic Surgery 028 Physical Medicine and Rehabilitation 029 Proctology 030 Psychiatry 031 Pulmonary Disease 032 Radiology 033 Rheumatology 034 Surgical Specialty Not Listed Here 035 Thoracic Surgery 036 Urology 037 Other Spec Not Listed (public health, industrial medicine) 038 Phys w/o Spec Identified & Spec Not Listed 039 Obstetrics/Gynecology **Other Health Care Professionals:** 040 Acupuncturist 041 Alcohol/Drug Detox Services 042 Ambulance Services 043 Audiologist/Speech Pathologist 044 Chiropractor 045 Freestanding Clinic – Not a Government Agency 046 Day Care Facility: Medical, Mental Health 047 Dietitian/Licensed Nutritionist 048 Home Health Provider 102 Mental Health Clinic 049 Advanced Practice Nurse: Anesthetist 050 Advanced Practice Nurse: Midwife 051 Advanced Practice Nurse: Nurse Practitioner 052 Advanced Practice Nurse: Psychotherapist

Field Name	COMAR	Description	Field Contents
Practitioner/Supplier Specialty (con't.)			053 Nurse – Other Than Advanced Practice 054 Occupational Therapist 055 Optometrist 056 Podiatrist 057 Physical Therapist 058 Psychologist 059 Clinical Social Worker 060 Public Health or Welfare Agency (federal, state, and local government) 061 Voluntary Health Agency 062 Other Specialty Not Listed Above 063 Respiratory Therapist 064 Physician Assistant **Dental:** 070 General Dentist 071 Endodontist 072 Orthodontist 073 Oral Surgeon 074 Pedodontist 075 Periodontist 076 Prosthodontist **Office Facilities:** 080 Freestanding Pharmacy (includes grocery) 081 Mail Order Pharmacy 082 Independent Laboratory 083 Independent Medical Supply Company 084 Optician/Optometrist (for lenses & eye glasses) 085 All Other Supplies 090 Freestanding Medical Facility 091 Freestanding Surgical Facility 092 Freestanding Imaging Center 093 Other facility
Practitioner DEA #	10.25.06.08.D.(12)	Drug Enforcement Agency number assigned to an individual registered under the Controlled Substance Act.	Same as DEA# in Pharmacy File.
Indicator for Multi-Practitioner Health Care Organization	10.25.06.08.D.(13)		0 Solo Practitioner 1 Multiple Practitioners

Field Name	COMAR	Description	Field Contents
Practitioner Individual National Provider Identifier (NPI) number	10.25.06.08.D.(14)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Practitioner Organizational National Provider Identifier (NPI) number	10.25.06.08.D.(15)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Payer ID Number		Payer assigned submission identification number (see Appendix A on page 38).	
Source System		Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 14, please be sure to list the source system that corresponds with the letter assigned.) For payers with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.

Data Dictionary – INSTITUTIONAL SERVICES

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.09 C.(1)	The value is 4	**4 Institutional Services**
Patient Identifier**P** (payer encrypted)	10.25.06.09 C.(2)	Patient's unique identification number assigned by payer and encrypted.	The unique ID for each person on this file should correspond to the same unique Patient ID used for all other files (Professional Services and Pharmacy Claims Files).
Patient Identifier**U** (UUID encrypted)	10.25.06.09 C.(2)	Patient's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 46. A full description is available in the UUID Users' Manual.
Patient Year and Month of Birth	10.25.06.09 C.(3)	Date of patient's birth using 00 instead of day.	CCYYMM00
Patient Sex	10.25.06.09 C.(4)	Sex of the patient.	1 Male 2 Female 3 Unknown
Patient Zip Code of Residence	10.25.06.09 C.(5)	Zip code of patient's residence.	5-digit US Postal Service zip code
Date of Enrollment	10.25.06.07.C.(6)	The start date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 66)	CCYYMMDD Date is 20120101 if patient is enrolled at start of 2012. Enter other date if patient **not enrolled** at start of year, enrolled during 2012.
Date of Disenrollment	10.25.06.07.C.(7)	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 66)	CCYYMMDD **Leave blank** if patient is still enrolled on 20121231. If patient disenrolled before end of year enter date disenrolled.
Hospital/Facility Federal Tax ID	10.25.06.09 C.(8)	Federal Employer Tax ID of the facility receiving payment for care.	
Hospital/Facility National Provider Identifier (NPI) Number	10.25.06.09 C.(9)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an organization for billing purposes.	Ten (10) digits www.cms.hhs.gov/NationalProvIdentStand/downloads/NPIfinalrule.pdf
Hospital/Facility Medicare Provider Number	10.25.06.09 C.(10)	Federal identifier assigned by the federal government for use in all Medicare transactions to an organization for billing purposes.	Six (6) digits
Hospital/Facility Participating Provider Flag	10.25.06.09 C.(11)	Indicates if the service was provided at a hospital/facility that participates in the payer's network.	1 Participating 2 Non-Participating 3 Unknown/Not Coded
Claim Control Number	10.25.06.09 C.(12)	Internal payer claim number used for tracking.	

Field Name	COMAR	Description	Field Contents
Record Type	10.25.06.09 C.(13)	Identifies the type of facility or department in a facility where the service was provided.	10 Hospital Inpatient – Undefined 11 Hospital Inpatient – Acute care 12 Hospital Inpatient – Children's Hospital 13 Hospital Inpatient – Mental health or Substance abuse 14 Hospital Inpatient – Rehabilitation, Long term care, SNF stay 20 Hospital Outpatient – Undefined 21 Hospital Outpatient – Ambulatory Surgery 22 Hospital Outpatient – Emergency Room 23 Hospital Outpatient – Other 30 Non-Hospital Facility
Type of Admission	10.25.06.09 C.(14)	Applies **only** to hospital inpatient records. All other record types code "0".	0 Not a hospital inpatient record 1 Emergency 2 Urgent 3 Elective 4 Newborn 5 Trauma Center 6 Reserved for National Assignment 7 Reserved for National Assignment 8 Reserved for National Assignment 9 Information Not Available
Point of Origin for Admission or Visit *(renamed from Source of Admission)*	10.25.06.09 C.(15)	Applies **only** to hospital inpatient records. All other record types code "0". (Note: Assign the code where the patient originated from before presenting to the health care facility.)	0 Not a hospital inpatient record For Newborns (Type of Admission = 4) 1 Normal delivery 2 Premature delivery 3 Sick baby 4 Not used 5 Born inside this hospital 6 Born outside of this hospital 9 Information not available Admissions other than Newborn 1 Non-Health Facility Point of Origin 2 Clinic or Physician's Office 3 Reserved for national assignment 4 Transfer from a Hospital (Different Facility) 5 Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) 6 Transfer from Another Health Care Facility 8 Court/Law Enforcement 9 Information Not Available

Field Name	COMAR	Description	Field Contents
Patient Discharge Status	10.25.06.09 C.(16)	Indicates the disposition of the patient at discharge. Applies **only** to hospital inpatient records. All other record types code "00".	00 Not a hospital inpatient record 01 Routine (home or self care) 02 Another Short-term Hospital 03 Skilled Nursing Facility (SNF) 04 Intermediate Care Facility 05 Another type of facility (includes rehab facility, hospice, etc.) 06 Home Health Care (HHC) 07 Against medical advice (AMA)/Discontinued care 09 Missing/Unknown 20 Died/Expired
Service from date/Start of Service (if Inpatient, Date of Admission)	10.25.06.09 C.(17)	First date of service for a procedure in this line item.	CCYYMMDD
Service thru date/End of Service (if Inpatient, Date of Discharge)	10.25.06.09 C.(18)	Last date of service for a procedure in this line item.	CCYYMMDD
Diagnosis Code Indicator		Indicates the volume of the International Classification of Diseases, Clinical Modification system used in assigning codes to diagnoses.	1 ICD-9-CM 2 ICD-10-CM 3 Missing/Unknown
Primary Diagnosis	10.25.06.09 C.(19)	The primary ICD-9-CM or ICD-10-CM Diagnosis Code followed by a secondary diagnosis (up to 29 codes), if applicable at the time of service. Remove embedded decimal pt.	
Primary Diagnosis Present on Admission (POA)	10.25.06.09 C.(20)	Primary Diagnosis present on Admission. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 1	10.25.06.09 C.(21)	ICD-9-CM/ICD-10-CM Diagnosis Code 1 Remove embedded decimal pt.	
Other Diagnosis Code 1 Present on Admission 1 (POA)	10.25.06.09 C.(22)	Diagnosis Code 1 present on Admission 1. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	COMAR	Description	Field Contents
Other Diagnosis Code 2	10.25.06.09 C.(23)	ICD-9-CM/ICD-10-CM Diagnosis Code 2 Remove embedded decimal pt.	
Other Diagnosis Code 2 Present on Admission 2 (POA)	10.25.06.09 C.(24)	Diagnosis Code 2 present on Admission 2. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 3	10.25.06.09 C.(25)	ICD-9-CM/ICD-10-CM Diagnosis Code 3 Remove embedded decimal pt.	
Other Diagnosis Code 3 Present on Admission 3 (POA)	10.25.06.09 C.(26)	Diagnosis Code 3 present on Admission 3. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 4	10.25.06.09 C.(27)	ICD-9-CM/ICD-10-CM Diagnosis Code 4 Remove embedded decimal pt.	
Other Diagnosis Code 4 Present on Admission 4 (POA)	10.25.06.09 C.(28)	Diagnosis Code 4 present on Admission 4. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 5	10.25.06.09 C.(29)	ICD-9-CM/ICD-10-CM Diagnosis Code 5 Remove embedded decimal pt.	
Other Diagnosis Code 5 Present on Admission 5 (POA)	10.25.06.09 C.(30)	Diagnosis Code 5 present on Admission 5. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 6	10.25.06.09 C.(31)	ICD-9-CM/ICD-10-CM Diagnosis Code 6 Remove embedded decimal pt.	
Other Diagnosis Code 6 Present on Admission 6 (POA)	10.25.06.09 C.(32)	Diagnosis Code 6 present on Admission 6. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 7	10.25.06.09 C.(33)	ICD-9-CM/ICD-10-CM Diagnosis Code 7 Remove embedded decimal pt.	
Other Diagnosis Code 7 Present on Admission 7 (POA)	10.25.06.09 C.(34)	Diagnosis Code 7 present on Admission 7. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	COMAR	Description	Field Contents
Other Diagnosis Code 8	10.25.06.09 C.(35)	ICD-9-CM/ICD-10-CM Diagnosis Code 8 Remove embedded decimal pt.	
Other Diagnosis Code 8 Present on Admission 8 (POA)	10.25.06.09 C.(36)	Diagnosis Code 8 present on Admission 8. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 9	10.25.06.09 C.(37)	ICD-9-CM/ICD-10-CM Diagnosis Code 9 Remove embedded decimal pt.	
Other Diagnosis Code 9 Present on Admission 9 (POA)	10.25.06.09 C.(38)	Diagnosis Code 9 present on Admission 9. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 10	10.25.06.09 C.(39)	ICD-9-CM/ICD-10-CM Diagnosis Code 10 Remove embedded decimal pt.	
Other Diagnosis Code 10 Present on Admission 10 (POA)	10.25.06.09 C.(40)	Diagnosis Code 10 present on Admission 10. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 11	10.25.06.09 C.(41)	ICD-9-CM/ICD-10-CM Diagnosis Code 11 Remove embedded decimal pt.	
Other Diagnosis Code 11 Present on Admission 11 (POA)	10.25.06.09 C.(42)	Diagnosis Code 11 present on Admission 11. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 12	10.25.06.09 C.(43)	ICD-9-CM/ICD-10-CM Diagnosis Code 12 Remove embedded decimal pt.	
Other Diagnosis Code 12 Present on Admission 12 (POA)	10.25.06.09 C.(44)	Diagnosis Code 12 present on Admission 12. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 13	10.25.06.09 C.(45)	ICD-9-CM/ICD-10-CM Diagnosis Code 13 Remove embedded decimal pt.	
Other Diagnosis Code 13 Present on Admission 13 (POA)	10.25.06.09 C.(46)	Diagnosis Code 13 present on Admission 13. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	COMAR	Description	Field Contents
Other Diagnosis Code 14	10.25.06.09 C.(47)	ICD-9-CM/ICD-10-CM Diagnosis Code 14 Remove embedded decimal pt.	
Other Diagnosis Code 14 Present on Admission 14 (POA)	10.25.06.09 C.(48)	Diagnosis Code 14 present on Admission 14. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 15	10.25.06.09 C.(49)	ICD-9-CM/ICD-10-CM Diagnosis Code 15 Remove embedded decimal pt.	
Other Diagnosis Code 15 Present on Admission 15 (POA)	10.25.06.09 C.(50)	Diagnosis Code 15 present on Admission 15. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 16	10.25.06.09 C.(51)	ICD-9-CM/ICD-10-CM Diagnosis Code 16 Remove embedded decimal pt.	
Other Diagnosis Code 16 Present on Admission 16 (POA)	10.25.06.09 C.(52)	Diagnosis Code 16 present on Admission 16. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 17	10.25.06.09 C.(53)	ICD-9-CM/ICD-10-CM Diagnosis Code 17 Remove embedded decimal pt.	
Other Diagnosis Code 17 Present on Admission 17 (POA)	10.25.06.09 C.(54)	Diagnosis Code 17 present on Admission 17. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 18	10.25.06.09 C.(55)	ICD-9-CM/ICD-10-CM Diagnosis Code 18 Remove embedded decimal pt.	
Other Diagnosis Code 18 Present on Admission 18 (POA)	10.25.06.09 C.(56)	Diagnosis Code 18 present on Admission 18. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 19	10.25.06.09 C.(57)	ICD-9-CM/ICD-10-CM Diagnosis Code 19 Remove embedded decimal pt.	
Other Diagnosis Code 19 Present on Admission 19 (POA)	10.25.06.09 C.(58)	Diagnosis Code 19 present on Admission 19. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	COMAR	Description	Field Contents
Other Diagnosis Code 20	10.25.06.09 C.(59)	ICD-9-CM/ICD-10-CM Diagnosis Code 20 Remove embedded decimal pt.	
Other Diagnosis Code 20 Present on Admission 20 (POA)	10.25.06.09 C.(60)	Diagnosis Code 20 present on Admission 20. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 21	10.25.06.09 C.(61)	ICD-9-CM/ICD-10-CM Diagnosis Code 21 Remove embedded decimal pt.	
Other Diagnosis Code 21 Present on Admission 21 (POA)	10.25.06.09 C.(62)	Diagnosis Code 21 present on Admission 21. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 22	10.25.06.09 C.(63)	ICD-9-CM/ICD-10-CM Diagnosis Code 22 Remove embedded decimal pt.	
Other Diagnosis Code 22 Present on Admission 22 (POA)	10.25.06.09 C.(64)	Diagnosis Code 22 present on Admission 22. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 23	10.25.06.09 C.(65)	ICD-9-CM/ICD-10-CM Diagnosis Code 23 Remove embedded decimal pt.	
Other Diagnosis Code 23 Present on Admission 23 (POA)	10.25.06.09 C.(66)	Diagnosis Code 23 present on Admission 23. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 24	10.25.06.09 C.(67)	ICD-9-CM/ICD-10-CM Diagnosis Code 24 Remove embedded decimal pt.	
Other Diagnosis Code 24 Present on Admission 24 (POA)	10.25.06.09 C.(68)	Diagnosis Code 24 present on Admission 24. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 25	10.25.06.09 C.(69)	ICD-9-CM/ICD-10-CM Diagnosis Code 25 Remove embedded decimal pt.	
Other Diagnosis Code 25 Present on Admission 25 (POA)	10.25.06.09 C.(70)	Diagnosis Code 25 present on Admission 25. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*

Field Name	COMAR	Description	Field Contents
Other Diagnosis Code 26	10.25.06.09 C.(71)	ICD-9-CM/ICD-10-CM Diagnosis Code 26 Remove embedded decimal pt.	
Other Diagnosis Code 26 Present on Admission 26 (POA)	10.25.06.09 C.(72)	Diagnosis Code 26 present on Admission 26. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 27	10.25.06.09 C.(73)	ICD-9-CM/ICD-10-CM Diagnosis Code 27 Remove embedded decimal pt.	
Other Diagnosis Code 27 Present on Admission 27 (POA)	10.25.06.09 C.(74)	Diagnosis Code 27 present on Admission 27. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 28	10.25.06.09 C.(75)	ICD-9-CM/ICD-10-CM Diagnosis Code 28 Remove embedded decimal pt.	
Other Diagnosis Code 28 Present on Admission 28 (POA)	10.25.06.09 C.(76)	Diagnosis Code 28 present on Admission 28. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Other Diagnosis Code 29	10.25.06.09 C.(77)	ICD-9-CM/ICD-10-CM Diagnosis Code 29 Remove embedded decimal pt.	
Other Diagnosis Code 29 Present on Admission 29 (POA)	10.25.06.09 C.(78)	Diagnosis Code 29 present on Admission 29. *Applies **only** to hospital inpatient records. All other record types code "0".*	Y – Yes = *Present at the time of inpatient admission* N – No = *Not present at the time of inpatient admission* U – Unknown = *Documentation is insufficient to determine if condition is present on admission* W – Clinically undetermined = *Provider is unable to clinically determine whether condition was present on admission or not* E – Unreported/Not used = *Exempt from POA reporting*
Attending Practitioner Individual National Provider Identifier (NPI) number	10.25.06.09 C.(79)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	The physician responsible for the patient's medical care and treatment. If outpatient or emergency room, this data element refers to the Practitioner treating patient at time of service.
Operating Practitioner Individual National Provider Identifier (NPI) number	10.25.06.09 C.(80)	Federal identifier assigned by the federal government for use in all HIPAA transactions to an individual practitioner.	This element identifies the operating physician who performed the surgical procedure.

Field Name	COMAR	Description	Field Contents
Billed Charge	10.25.06.09 C.(81)	A provider's billed charges rounded to whole dollars. **DO NOT USE DECIMALS**	
Allowed Amount	10.25.06.09 C.(82)	Total patient and payer liability. **DO NOT USE DECIMALS**	
Reimbursement Amount	10.25.06.09 C.(83)	Amount paid by carrier to Tax ID # of provider as listed on claim. **DO NOT USE DECIMALS**	
Total Patient Deductible	10.25.06.09 C.(84)	The fixed amount that the patient must pay for covered medical services/hospital stay before benefits are payable.	
Total Patient Coinsurance or Patient Co-payment	10.25.06.09 C.(85)	The specified amount or percentage the patient is required to contribute towards covered medical services/hospital stay after any applicable deductible.	
Total Other Patient Obligations	10.25.06.09 C.(86)	Any patient liability other than the deductible or coinsurance/co-payment. This could include obligations for out-of-network care (balance billing net of patient deductible, patient coinsurance/co-payment and payer reimbursement), non-covered services, or penalties. **DO NOT USE DECIMALS**	

*Note: Note: Total Patient Liability **should equal the sum** of Patient Deductible (84), Patient Coinsurance/Co-payment (85), and Other Patient Obligations (86).*

Coordination of Benefit Savings or Other Payer Payments	10.25.06.09 C.(87)	If you are not the primary insurer, report the amount paid by the primary payer.	

Field Name	COMAR	Description	Field Contents
Type of Bill	10.25.06.09 C.(88)	UB 04 or UB 92 form 3-digit code = Type of Facility + Bill Classification + Frequency	**Type of Facility – 1st digit** 1 Hospital 2 Skilled Nursing 3 Home Health 4 Christian Science Hospital 5 Christian Science Extended Care 6 Intermediate Care 7 Clinic 8 Special Facility **Bill Classification – 2nd Digit if 1st Digit = 1-6** 1 Inpatient (including Medicare Part A) 2 Inpatient (including Medicare Part B Only) 3 Outpatient 4 Other (for hospital referenced diagnostic services or home health not under a plan of treatment) 5 Nursing Facility Level I 6 Nursing Facility Level II 7 Intermediate Care – Level III Nursing Facility 8 Swing Beds **Bill Classification – 2nd Digit if 1st Digit = 7** 1 Rural Health 2 Hospital-based or Independent Renal Dialysis Center 3 Freestanding Outpatient Rehabilitation Facility (ORF) 4 Comprehensive Outpatient Rehabilitation Facilities (CORFs) 5 Community Mental Health Center 9 Other **Bill Classification – 2nd Digit if 1st Digit = 8** 1 Hospice (Non-Hospital based) 2 Hospice (Hospital-based) 3 Ambulatory Surgery Center 4 Freestanding Birthing Center 9 Other **Frequency – 3rd Digit** 1 Admit through Discharge 2 Interim – First Claim Used 3 Interim – Continuing Claims 4 Interim – Last Claim 5 Late Charge Only 6 Adjustment of Prior Claim 7 Replacement of Prior Claim 8 Void/Cancel of Prior Claim

Field Name	COMAR	Description	Field Contents
Patient Covered by Other Insurance Indicator	10.25.06.09 C.(89)	Indicates whether patient has additional insurance coverage.	0 No 1 Yes, other coverage is primary 2 Yes, other coverage is secondary 9 Unknown
Procedure Code Indicator	10.25.06.09 C.(90)	Indicates the classification used in assigning codes to procedures.	1 ICD-9-CM 2 ICD-10-CM 3 CPT Code/HCPCS
Principal Procedure Code 1	10.25.06.09 C.(91)	The principal health care service provided, followed by a secondary procedure (up to 15 codes), if applicable at the time of service. **Remove embedded decimal pt.**	CPT Codes are required on all non-inpatient claims (ER, clinic, outpatient), but will allow ICD-9-CM or ICD-10-CM Codes for inpatient claims.
Procedure Code1 Modifier I	10.25.06.09 C.(92)	Discriminate code used by practitioners to distinguish that a health care service has been altered [by a specific condition] but not changed in definition or code. A modifier is added as a suffix to a procedure code field.	Modifier applies only to CPT Codes.
Procedure Code1 Modifier II	10.25.06.09 C.(93)	Specific to Modifier I.	
Other Procedure Code 2	10.25.06.09 C.(94)	Remove embedded decimal pt.	
Procedure Code2 Modifier I	10.25.06.09 C.(95)		Modifier applies only to CPT Codes.
Procedure Code2 Modifier II	10.25.06.09 C.(96)		
Other Procedure Code 3	10.25.06.09 C.(97)	Remove embedded decimal pt.	
Procedure Code3 Modifier I	10.25.06.09 C.(98)		Modifier applies only to CPT Codes.
Procedure Code3 Modifier II	10.25.06.09 C.(99)		
Other Procedure Code 4	10.25.06.09 C.(100)	Remove embedded decimal pt.	
Procedure Code4 Modifier I	10.25.06.09 C.(101)		Modifier applies only to CPT Codes.
Procedure Code4 Modifier II	10.25.06.09 C.(102)		
Other Procedure Code 5	10.25.06.09 C.(103)	Remove embedded decimal pt.	
Procedure Code5 Modifier I	10.25.06.09 C.(104)		Modifier applies only to CPT Codes.
Procedure Code5 Modifier II	10.25.06.09 C.(105)		
Other Procedure Code 6	10.25.06.09 C.(106)	Remove embedded decimal pt.	
Procedure Code6 Modifier I	10.25.06.09 C.(107)		Modifier applies only to CPT Codes.
Procedure Code6 Modifier II	10.25.06.09 C.(108)		

Field Name	COMAR	Description	Field Contents
Other Procedure Code 7	10.25.06.09 C.(109)	Remove embedded decimal pt.	
Procedure Code7 Modifier I	10.25.06.09 C.(110)		Modifier applies only to CPT Codes.
Procedure Code7 Modifier II	10.25.06.09 C.(111)		
Other Procedure Code 8	10.25.06.09 C.(112)	Remove embedded decimal pt.	
Procedure Code8 Modifier I	10.25.06.09 C.(113)		Modifier applies only to CPT Codes.
Procedure Code8 Modifier II	10.25.06.09 C.(114)		
Other Procedure Code 9	10.25.06.09 C.(115)	Remove embedded decimal pt.	
Procedure Code9 Modifier I	10.25.06.09 C.(116)		Modifier applies only to CPT Codes.
Procedure Code9 Modifier II	10.25.06.09 C.(117)		
Other Procedure Code 10	10.25.06.09 C.(118)	Remove embedded decimal pt.	
Procedure Code10 Modifier I	10.25.06.09 C.(119)		Modifier applies only to CPT Codes.
Procedure Code10 Modifier II	10.25.06.09 C.(120)		
Other Procedure Code 11	10.25.06.09 C.(121)	Remove embedded decimal pt.	
Procedure Code11 Modifier I	10.25.06.09 C.(122)		Modifier applies only to CPT Codes.
Procedure Code11 Modifier II	10.25.06.09 C.(123)		
Other Procedure Code 12	10.25.06.09 C.(124)	Remove embedded decimal pt.	
Procedure Code12 Modifier I	10.25.06.09 C.(125)		Modifier applies only to CPT Codes.
Procedure Code12 Modifier II	10.25.06.09 C.(126)		
Other Procedure Code 13	10.25.06.09 C.(127)	Remove embedded decimal pt.	
Procedure Code13 Modifier I	10.25.06.09 C.(128)		Modifier applies only to CPT Codes.
Procedure Code13 Modifier II	10.25.06.09 C.(129)		
Other Procedure Code 14	10.25.06.09 C.(130)	Remove embedded decimal pt.	
Procedure Code14 Modifier I	10.25.06.09 C.(131)		Modifier applies only to CPT Codes.
Procedure Code14 Modifier II	10.25.06.09 C.(132)		
Other Procedure Code 15	10.25.06.09 C.(133)	Remove embedded decimal pt.	
Procedure Code15 Modifier I	10.25.06.09 C.(134)		Modifier applies only to CPT Codes.
Procedure Code15 Modifier II	10.25.06.09 C.(135)		

Field Name	COMAR	Description	Field Contents
Diagnosis Related Groups (DRGs) Number	10.25.06.09 C.(136)	The inpatient classifications based on diagnosis, procedure, age, gender and discharge disposition.	
DRG Grouper Name	10.25.06.09 C.(137)	The actual DRG Grouper used to produce the DRGs.	1 All Patient DRGs (AP-DRGs) 2 All Patient Refined DRGs (APR-DRGs) 3 Centers for Medicare & Medicaid Services DRGs (CMS-DRGs) 4 Other Proprietary
DRG Grouper Version	10.25.06.09 C.(138)	Version of DRG Grouper used.	
Payer ID Number		Payer assigned submission identification number (see Appendix A on page 38).	
Source System		Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 14, please be sure to list the source system that corresponds with the letter assigned.) For payers with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.

Data Dictionary – MEDICAL ELIGIBILITY

Field Name	COMAR	Description	Field Contents
Record Identifier	10.25.06.10 C.(1)	The value is 5	**5 Medical Eligibility**
Encrypted Enrollee Identifier**P** (payer encrypted)	10.25.06.10 C.(2)	Enrollee's unique identification number assigned by payer and encrypted.	The unique ID for each person on this file would correspond to the same unique Patient/Enrollee ID used for all other files (Professional Services, Pharmacy Claims, and Institutional Services Files).
Encrypted Enrollee Identifier**U** (UUID encrypted)		Enrollee's universally unique identification (UUID) number generated using an encryption algorithm provided by MHCC.	Refer to the UUID summary description sheet on page 46. A full description is available in the UUID Users' Manual.
Enrollee Year and Month of Birth	10.25.06.10 C.(3)	Date of enrollee's birth using 00 instead of day.	CCYYMM00
Enrollee Sex	10.25.06.10 C.(4)	Sex of the enrollee.	1 Male 2 Female 3 Unknown
Enrollee Zip Code of Residence	10.25.06.10 C.(5)	Zip code of enrollee's residence.	5-digit US Postal Service code

Field Name	COMAR	Description	Field Contents
Enrollee County of Residence	10.25.06.10 C.(6)	County of enrollee's residence. If known, please provide. If not known, MHCC will arbitrarily assign using Zip code of residence.	001 Allegany 003 Anne Arundel 005 Baltimore County 009 Calvert 011 Caroline 013 Carroll 015 Cecil 017 Charles 019 Dorchester 021 Frederick 023 Garrett 025 Harford 027 Howard 029 Kent 031 Montgomery 033 Prince George's 035 Queen Anne's 037 St. Mary's 039 Somerset 041 Talbot 043 Washington 045 Wicomico 047 Worcester 510 Baltimore City 999 Unknown *County codes based on the U.S. Census Bureau's Federal Information Processing Standards (FIPS).*
Source of Enrollee Race/Ethnicity Information	10.25.06.10 C.(7)	Race/ethnicity of enrollee gathered from enrollee or other source.	0 Enrollee not asked 1 Enrollee asked and reported 2 Enrollee asked but refused 3 Obtained from other source
Enrollee OMB Race 1	10.25.06.10 C.(8)	Race of enrollee.	1 American Indian or Alaska Native 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White/Caucasian 6 Some Other Race 9 Missing/Unknown/Not specified

Field Name	COMAR	Description	Field Contents
Enrollee OMB Race 2	10.25.06.10 C.(9)	Race of enrollee.	1 American Indian or Alaska Native 2 Asian 3 Black or African American 4 Native Hawaiian or Other Pacific Islander 5 White/Caucasian 6 Some Other Race 9 Missing/Unknown/Not specified
Enrollee OMB Race 3 *(for future use)*			For Future Use
Enrollee OMB Hispanic Ethnicity 1 (Hispanic Indicator)	10.25.06.10 C.(10)	Ethnicity of enrollee.	1 Hispanic or Latino or Spanish origin 2 Not Hispanic or Latino or Not of Spanish origin 9 Missing/Unknown/Not specified
Enrollee Other Ethnicity 2 *(for future use)*	10.25.06.10 C.(11)		For Future Use
Enrollee Preferred Spoken Language *(for future use)*	10.25.06.10 C.(12)	A locally relevant list of languages will be developed by the Commission in consort with the Racial, Ethnic and Language Disparities Work Group.	For Future Use
Coverage Type	10.25.06.10 C.(13)	Enrollee's type of insurance coverage.	1 Medicare Supplemental (i.e., Individual, Group, WRAP) 2 Medicare Advantage Plan 3 Individual Market (not MHIP) 4 Maryland Health Insurance Plan (MHIP) 5 Private Employer Sponsored or Other Group (i.e. union or association plans) 6 Public Employee – Federal (FEHBP) 7 Public Employee – Other (state, county, local/municipal government and public school systems) 8 Comprehensive Standard Health Benefit Plan [a self employed individual or small businesses (public or private employers) with 2-50 eligible employees] 9 Health Insurance Partnership (HIP) A Student Health Plan Z Unknown

Field Name	COMAR	Description	Field Contents
Source Company *(renamed from Delivery System Type)*	10.25.06.10 C.(14)	Defines the payer company that holds the beneficiary's contract; for use in characterizing contract requirements under Maryland law.	1 Health Maintenance Organization 2 Life & Health Insurance Company or Not-for-Profit Health Benefit Plan 3 Third-Party Administrator (TPA) Unit
Product Type		Classifies the benefit plan by key product characteristics (scope of coverage, size of network, coverage for out-of-network benefits). (Please code based on how the product is primarily marketed, and most importantly be consistent from year to year. If not sure, send an e-mail describing the product to Larry Monroe at larry.monroe@maryland.gov)	1 Exclusive Provider Organization (in any form) 2 Health Maintenance Organization 3 Indemnity 4 Point of Service (POS) 5 Preferred Provider Organization (PPO) 6 Limited Benefit Plan (Mini-Meds) 7 Student Health Plan 8 Catastrophic
Policy Type	10.25.06.10 C.(15)	Type of policy.	1 Individual 2 Any combination of two or more persons
Encrypted Contract or Group Number (payer encrypted)	10.25.06.10 C.(17)	Payer assigned contract or group number for the plan sponsor using an encryption algorithm generated by the payer.	This number should be the same for all family members on the same plan.
Employer Federal Tax ID Number	10.25.06.10 C.(18)	Employer Federal Tax ID number will be encrypted by the database contractor in such a way that an employer will have the same encrypted ID across all payer records and the same employer has the same encrypted number from year to year.	
Medical Services Indicator	10.25.06.10 C.(19)	Medical Coverage	0 No 1 Yes
Pharmacy Services Indicator	10.25.06.10 C.(20)	Prescription Drug Coverage	0 No 1 Yes
Behavioral Health Services Indicator	10.25.06.10 C.(21)	Behavioral Health Services Coverage	0 No 1 Yes
Dental Services Indicator	10.25.06.10 C.(22)	Dental Coverage	0 No 1 Yes

Field Name	COMAR	Description	Field Contents
Plan Liability	10.25.06.10 C.(23)	Indicates if insurer is at risk for the patient's service use or the insurer is simply paying claims as an ASO.	1 Risk (under Maryland contract) 2 Risk (under non-Maryland contract) 3 ASO (employer self-insured)
Consumer Directed Health Plan (CDHP) with HSA or HRA Indicator	10.25.06.10 C.(24)	Consumer Directed Health Plan (CDHP) with Health Savings Account (HSA) or Health Resources Account (HRA).	0 No 1 Yes
Start Date of Coverage (in the month)		The start date for benefits in the month (for example, if the enrollee was insured at the start of the month of January in 2012, the start date is 20120101)	CCYYMMDD
End Date of Coverage (in the month)		The end date for benefits in the month (for example, if the enrollee was insured for the entire month of January in 2012, the end date is 20120131)	CCYYMMDD
Date of FIRST Enrollment	10.25.06.10 C.(25)	The date of that the patient was initially enrolled with your organization.	CCYYMMDD
Date of Disenrollment	10.25.06.10 C.(26)	The end date of enrollment for the patient in this delivery system (in this data submission time period). (see Source Company on page 95)	CCYYMMDD **Leave blank** if patient is still enrolled on 20121231. If patient disenrolled before end of year enter date disenrolled.
Relationship to Policyholder	10.25.06.10 C.(27)	Member's relationship to subscriber/insured.	1 Self/employee 2 Spouse 3 Child 4 Other Dependent 5 Other Adult 9 Unknown
Payer ID Number		Payer assigned submission identification number. (see Appendix A on page 38)	
Source System		Identify the source system (platforms or business units) *from which the data was obtained* by using an alphabet letter (A, B, C, D, etc…) (Note: In your documentation on page 14, please be sure to list the source system that corresponds with the letter assigned.) For payers with all data coming from one system only, leave the field blank.	A – Z Leave the field **blank** if submitting data from **one (1)** platform or business unit only.

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